S. HRG. 107–454

ACCESS TO VA HEALTH CARE IN WEST VIRGINIA

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTH CONGRESS

FIRST SESSION

JULY 16, 2001—HUNTINGTON, WV

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ACCESS TO VA HEALTH CARE IN WEST VIRGINIA

MONDAY, JULY 16, 2001

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:43 a.m., in Shawkey Dining Room, Memorial Student Center, Marshall University, Huntington, WV, Hon. John J. Rockefeller IV (chairman of the committee) presiding.

Present: Senator Rockefeller.

Chairman ROCKEFELLER. The hearing will come to order. I am very pleased that you are all here. I have a short statement that I am going to give. That is the penalty for your attendance—you get a short statement. But a statement is useful in that it sets the tone for what we are talking about and why we are talking about it and why we are asking these particular types of questions.

We had a hearing in 1993 and we discussed some of these same things. It is interesting to me now, 8 years later, back when I am again chairman of Veterans', that I can do this again and get at some of these issues. The whole question of access to health care obviously is crucial to me, because if you don't have access to health care, you don't get it. Access equals health care. That has always been a problem, and it is particularly a problem in a rural State. It will always be that way and I have a variety of things I want to say about that.

So anyway, I am very happy that we have a panel of veterans and they are going to talk about what needs to be done to improve the access to good health care for veterans in West Virginia, in particular—in rural areas generically but West Virginia in particular. The rural problem is always different, always more complicated, always less well served, and so that is of interest to me.

We also have VA officials who are here and are going to talk to us about what some of their plans are, about what they hear in the first panel and also some other questions I will have for them.

I think it is a little ironic that when we met in 1993, I commented that at that time, we were one of the very few areas that were not being devastated by floods. The country was suffering many floods back then; I don't particularly remember where they were, but we weren't having them here. For some reason, I chose to make a comment about that. I am not quite sure why I did, but it is a little different today, isn't it?

I had a lot of things I was scheduled to do today and just canceled them because I want to get down again into the flooded terri-

tories. Floods are something that people don't understand until they get into the middle of them, and into the minds of people that have been affected by them. The devastation they cause is so much more than pictures or cameras can catch because they last. Flood victims can get PTSD, just like those who were in Vietnam, Korea, World War II, the Persian Gulf, and other places.

So today, we have some of the worst floods in years. I don't compare floods because I don't see any advantage. All floods are awful in my view, so I don't compare floods of this decade to floods of another decade. They are all terrible.

I want to commend the VA, and especially the VA Medical Center in Beckley. They have helped out a great deal in this, and I appreciate that.

In 1993, when former VA Secretary Brown joined us in Beckley, he wanted to talk about the challenges that the VA faced then: the reorganization of the VA health care system and how to decide who should be eligible for VA care. So today, I turn to you to learn how these changes which have taken place in VA health care delivery—the rapid increase in community clinics, eligibility reform, the network organization, which is an interesting phenomenon—how these have affected veterans' access to basic as well as to specialized health care.

Unfortunately, many of the problems discussed 8 years ago remain with us, and that is the way it often is with health care. You don't just solve the problem. It is too big. It is too far-reaching. It is too deep.

We still have with us the fight for an adequate budget, and I will have a word to say about that. We have long waiting times for health care, for attention. I want to talk about that. We have too few VA staff providing specialized care. Some, including Randy, will be talking about that. We have a lack of long-term care, even though we passed a bill 2 years ago to mandate that for certain groups of veterans. That has not yet taken shape. We have transportation obstacles for veterans traveling to and between VA centers. That was a problem then and still is. We want to hear about that.

In 1993, veterans voiced their concerns about access to and copayments for prescription drugs. I want to hear a little bit about that. Our veterans population obviously is not getting younger, and we have not enacted a prescription drug coverage bill under Medicare in Congress. I think we have got a shot at doing it this year, a good one, a good one, but we are constrained by the tax cut to only doing—it will sound huge, but it isn't when you look at the whole country—$300 billion over a period of 10 years. That is not the kind of prescription drug benefit plan that we need. It ought to be closer to $400 billion, but because of the tax cut, some veterans won't be getting anything; some won't be getting prescription drugs while others enjoy tax cuts. It is a question of tradeoffs. I mean, how much do we value our veterans, what do we owe them, et cetera. To me, the answer is very clear.

I want to repeat again that I really do believe a lot in outpatient clinics. I think they are a special benefit for States like West Virginia. Every time that we have placed one, and we have a lot of them now with more coming, it seems to me that they become real

points of access, not just physically, but psychologically. People feel, "Oh, that is pretty close. I will just go there," as opposed to if they have to go to a center or some other place where they might just say, "Well, you know, I could go there, but it is a long way. I don't think I will." And that "I don't think I will go" for health care can be a very dangerous decision to make. So it is a good thing, having those outpatient clinics, in my judgment.

With eligibility reform, we increased the number of veterans who receive primary care, but this must not come at the cost of the specialized programs. These are the two critical areas to balance, the basic and the specialized. We have more of the basic now than we do the specialized. That is a problem, because the VA generally has excelled at specialized programs, doctors, and their services, and it is something that veterans particularly need, so we need to talk about that.

VA is now organized into 22 different service networks. Obviously, that has clearly changed VA health care delivery. We are in an amazing position in West Virginia in that we have four different VA centers and they belong to four different, as we say, VISN's. How do people feel about that? It is not something we are going to change, so it is a question of how do we make it work, and it is one of the important areas where oversight, which is what the Veterans' Committee does, can be very helpful.

It is impossible to expect that every West Virginia veteran can get access to every kind of specialized care close to home. That probably isn't something which is going to happen. That is too good of a world. So you get to transfers. You transfer to people where they can get the best possible specialized care, and the question is how can those transfers happen as efficiently and humanely and rapidly as possible. VA's network and hospital directors have to, I think, make sure that there are not any barriers to these forms of transfer, getting people where they need to go as quickly as possible, and I want to talk about that.

I am going to end on a cautionary note. After the tax cut bill, which you, I hope, know that I worked against, talked against, voted against, and still do talk against and will continue until something happens, there is not going to be enough money available. The Congress made a decision—in my judgment, a wrong one, a very, very wrong one, a profoundly wrong one—in which they said that we are going to pretty much guarantee that veterans don't get the health care that they need, that we don't get the kind of services that we in West Virginia need sometimes more than other people in other States because we are so mountainous and water and sewer become so important, highways become so important, transportation becomes so important, health care becomes so important. All of these things, Medicare and Medicaid, veterans' care, all of them come out of Federal funds. They don't come out of the private sector. They just don't. They come out of something called Federal funds.

After that budget resolution was adopted by the Congress, I just have to tell you, I have no choice but to tell you that there is not going to be enough money to do veterans' care the way we should. And until and unless we come to our senses and do something about that bill—and I am not sure that we are going to, because

there was such a rush and a mania to return money to people—which I am for, but if I had done that, I would have made a cut in the payroll taxes, not in the income taxes. The income taxes often go to people that don't need it nearly as much, and payroll taxes, by definition, goes to anybody who is working.

But, nevertheless, that tax cut was adopted. It passed the Congress. We have to deal with it. So the budget increase for both health care and benefits administration is not enough as it is, and it is not going to be even enough now to keep pace with inflation. I have a duty to tell you that, because it is true. Again, it is a decision that others in the Congress made, not me, and it is something that I feel will do serious damage to our country, our educational system, and a lot of other important parts of our national future. But the Congress made that decision and the President made that decision and that decision was passed and signed, so it is now a fact of life.

So we are not going to have what we need. I think the chances of getting it back are not good right now. I will do everything I can to fight to change that. I don't know what that means right now. I don't expect much result from that, certainly now. But I have to be candid with you and I have to note that the prospects are not good.

With that said, we fight on. We always fight on and we do the best we can. In West Virginia, doing the best we can sometimes is pretty good. Human effort and care and love can make up for a lot.

[The prepared statement of Chairman Rockefeller follows:]

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Good morning. I welcome all of you here.

It is good to be back in West Virginia for a Senate Veterans' Affairs Committee field hearing—and I like it all the better as the new Chairman. I know that a few of you in this room remember a hearing that the Committee held in 1993 on this very subject—access to VA health care in West Virginia, which remains a priority for me.

I am pleased today that we are joined by a panel of veterans who can describe what needs to be done to improve access to high quality VA health care for veterans in rural areas, especially in West Virginia. Later, we will hear from VA officials who will help us understand how they propose to solve these problems.

It is ironic that when we met in 1993, I commented that it was one of the few times that other parts of the country were devastated by floods while West Virginia remained safe. Today, West Virginians—including some here today—are contending with the aftermath of the worst floods in twenty years. I commend VA, especially the Beckley VA medical center, for rising to the occasion to help veterans in need during this disaster.

In 1993, former VA Secretary Brown joined us in Beckley to talk about the challenges that VA faced then—the reorganization of VA's health care system, and how to decide who should be eligible for VA care. Today, I turn to you to learn how these changes in VA's healthcare delivery—the rapid increase in community clinics, eligibility reform, and the network organization—have affected veterans' access to basic and specialized medical care.

Unfortunately, many of the problems discussed eight years ago remain with us: the fight for an adequate budget, long waiting times for care, too few VA staff providing specialized care, a lack of long-term care services, and transportation for veterans traveling to or between VA medical centers. In 1993, veterans voiced their concerns about access to, and co-payments for, prescription drugs. As our veterans population ages, and Congress continues to fail to enact prescription drug coverage under Medicare, these concerns grow even more pressing.

Over recent years, VA has increased access to primary health care by opening community based outpatient clinics. I have worked closely with VA to open many of these clinics in West Virginia. Community outpatient clinics are enormously im-

portant to veterans who might otherwise have to travel for hours for the most basic primary health care. However, it is not just enough to increase the points of access—veterans who use these clinics should be able to expect and receive the highest quality healthcare possible.

With eligibility reform, VA increased the number of veterans who receive primary care, but this must not come at the cost of the specialized programs at which VA has excelled—and that some veterans so desperately need.

The reorganization of VA into twenty-two service networks has clearly changed VA health care delivery. We are in a unique position in West Virginia in that our four VA medical centers are each in a different VA network. While this may create some problems for us, it also presents a wonderful oversight opportunity.

Although it is impossible to expect that every West Virginia veteran can access every kind of specialized care close to home, it is essential that—should they need services only available at distant VA or private facilities—their transfers happen as simply and efficiently as possible. VA's network and hospital directors must ensure that no barriers exist to coordinating and managing care between medical centers or between networks.

Let me end on a cautionary note: after the tax cut, there is simply not enough money available—either in the President's budget or the Budget Resolution adopted by the Congress—for veterans' health care. The budget increase for both health care and benefits administration is not even enough to keep pace with inflation. I will continue to fight for more funding in the appropriations process, but I must be candid and note that the prospects are not good.

That said, we must try to identify the problems in access to rural health care, and how we will solve these problems, with the resources that we have. I look forward to hearing from our witnesses.

Chairman ROCKEFELLER. Now let us go on to our first panel, which has been patiently waiting right here before me. Randy Pleva, a longtime friend of mine, lives in Charleston, and is President of the West Virginia Chapter of the Paralyzed Veterans of America, one of five national PVA Vice Presidents. Randy was with Secretary Principi and myself as we were in various places and Randy has a variety of things that affect him personally and that affect him professionally.

I am going to introduce each of you, and then I am going to ask you to go ahead and make comments and statements.

Jake Stafford is Chairman of the State Veterans' Coalition, Legislative Officer of West Virginia Disabled American Veterans, DAV, and National DAV Executive Committee member, so he is thoroughly involved and he is living in Oceana. I won't be going there this afternoon, but I will be going close by, particularly to Mullens. Jake comes every year to DC to meet with me to make sure that I am abreast of veterans' concerns in West Virginia. He is going to talk about waiting times and anything else he wants to, as well as the specialty treatment.

Randy Sims is a member of the Parkersburg DAV Chapter 32, and Randy lives in Belpre, but was born in Parkersburg and grew up in Williamstown, WV. I have always felt that people go back and forth on both sides of the river and we are all family in that sense, so we don't make a big distinction between whether you live in Belpre or whether you live in Williamstown. You are part of our area of concern. With Randy is his wife, Beth, and also his father, Paul Sims, who is an ex-POW who spent a year in a German prison camp in World War II, and Vera Hill, one of the health care workers that they have hired to help with Paul's care. Paul is a 100 percent service-connected disabled veteran, and with him, we want to get to the question, and with you, Randy, to the question of long-term care.

Luther, I didn't pass you by. You are a Vietnam veteran. You retired with 23 years in the Army and you have a number of health care problems, which I won't go into. You are 100 percent service-connected for a variety of reasons, you live in Welch, and you are very active in local veterans' service organizations. I think that you are going to focus on a recent hospitalization in Huntington, and you may have some other comments—you were running short of breath one time and you called our office, and you may want to comment on that. You were told that you couldn't have surgery done, you had to go to St. Mary's. You had surgery done in St. Mary's because you didn't want to wait, because you didn't think you could wait. The VA said no, St. Mary's said yes, and you went ahead. You probably did the right thing.

So with that in mind, Randy, why don't we start with you. Make yourself available to the microphone, since this is all on the record and part of official congressional testimony. I welcome you very much and am very happy to see you.

STATEMENT OF RANDY PLEVA, PRESIDENT, WEST VIRGINIA PARALYZED VETERANS OF AMERICA (PVA), AND NATIONAL PVA VICE PRESIDENT, CHARLESTON, WV

Mr. PLEVA. Yes, Mr. Chairman. Thank you and the members of the committee. Paralyzed Veterans of America appreciates this opportunity to express our views on spinal cord injury health care in the State of West Virginia.

Mr. Chairman, as I look back at the testimony that I gave 8 years ago, just to see, if in fact, health care has improved. I found, and I am glad to report, that it has with the SCI primary care teams in all four VA Hospitals with more nurses and physicians receiving training and certification in the SCI field. In addition, more of the SCI population is using the VA system than they were 8 years ago due to the trust SCI veterans have in the primary care team members.

One thing that took longer to change than anything else is going to the SCI center itself. Transfers, until 3 months ago, not only were a nightmare for the veteran, but also for the person in the VA trying to get someone transferred. Mr. Chairman, as you are well aware, we contacted Ms. Moreland on a number of occasions when this situation occurred. Then and only then, did these transfers become reality. Somewhere someone was not doing their job. As of March of this year, all four VA hospitals in the State have reported no trouble at all when it comes to transferring an SCI patient. Let me reassure this committee, WV–PVA will be in contact with each SCI coordinator to make sure transfers are no longer a problem.

As I stated before, more SCI veterans are using the VA system but are not going to the SCI centers for their annual checkups for various reasons. Some reasons would shock this committee, as it did me when I sat and listened to not only the veteran, but to also family members. Out of 225 members, only 8 percent went for annual checkups at an SCI Center inpatient care. Just as it was 8 years ago, bowel care in still a concern. I have been told that this concern is being addressed and that is due to the turnover of nurses on the ward. That the new nurses will be trained soon.

However, to the SCI patient soon is not fast enough. Today is the time. Mr. Chairman, we are not asking for a magic wand to fix everything at one time, but if the SCI primary care team can be trained, why can't the nurses and aides on the wards be trained also? I don't mean to sound like the author of doom, good has come to the SCI health care in West Virginia and for the first time in years, the VA is being trusted. But also remember, it has taken 8 years to get this far, and we are only a few feet from the starting line when it comes to quality health care for the catastrophically disabled veteran.

Mr. Chairman, this concludes my testimony and I will be happy to respond to any questions you may have, sir.

Chairman ROCKEFELLER. I will give you one right now, although this is out of order. You say that most of them don't go for regular check-ups, by which you are saying that they go if there is a crisis, but they don't go for a regular status check-up?

Mr. PLEVA. Right. They don't go for annual check-ups, no, sir.

Chairman ROCKEFELLER. But they do go for——

Mr. PLEVA. No, sir, they don't even go—I mean, they were——

Chairman ROCKEFELLER. No, but when they do go.

Mr. PLEVA. Oh, yes. Well, when they do go, yes, their skin ulcer has gone to a stage four or something of this nature before they will even go into the VA, before they even think about going to an SCI center, due to reasons. I wish I could tell you, I mean, and I will, but I think it is something that should be privately done, sir.

Chairman ROCKEFELLER. OK. I appreciate it.

Jake?

STATEMENT OF JACOB STAFFORD, CHAIRMAN, STATE VETERANS' COALITION, LEGISLATIVE OFFICER, WEST VIRGINIA DISABLED AMERICAN VETERANS (DAV), AND NATIONAL DAV EXECUTIVE COMMITTEE MEMBER, OCEANA, WV

Mr. STAFFORD. On behalf of West Virginia Disabled American Veterans and their auxiliary, I am pleased to be here before this committee. We would like to thank you at the outset for your many endeavors and commend you and the committee for what you have done for the veterans in the State of West Virginia and across the Nation in the last few years.

I would like to talk just a little bit about an adequate budget. I know you have touched on it, but our problems in West Virginia and across this country started with 3 years of flat-line budgets. We have had a couple of years that are pretty good and helped us get back on our feet a little bit. Right now, I am tremendously worried about the fundings that we have got coming.

I know the Independent Budget, with the AMVETS, the DAV, the VFW, and Paralyzed Veterans, they are calling for $3.5 billion, $2.66 billion of that for health care. The President's proposal is $1 billion for all discretionary spending, and basically, that is what we need just for the "other than" VHA health care.

Chairman ROCKEFELLER. Actually, it doesn't even do that. It doesn't even keep us where we were last year.

Mr. STAFFORD. Right. And the reason that we need these funds is because of the cost-of-living increases, unfunded mandates that were passed by you guys last year. If we could get something simi-

lar to this, it wouldn't have the adverse effect to America's sick and disabled veterans.

Most of the health care problems we have had in the last 4 years have been because of underfunding, and hopefully, we will not see this again, but it doesn't seem that we won't have it.

I would like to touch on all four VA hospitals and the problems on the specialized service. Beckley, the veterans receive specialized care in Richmond, Salem, and Durham. You have a 2.5- to 4-month waiting period for the first-time visit and specialty clinics at these facilities. This is a very serious problem when the veteran has a life-threatening health care issue. If they get into the system, the appointments come as needed. Non-life-threatening treatment can take 6 months to a year, and in some cases longer for an appointment.

Transportation problems at Beckley for underprivileged veterans trying to get to Richmond. Richmond, Durham is about 5.5 hours away, Salem about 2.5 hours, and this has created great problems for veterans getting to the facilities and back home. Most have low income and can't afford the cost of long-distance travel and food costs.

At Beckley, the VA furnishes transportation to Richmond VAMC. Everyone has to stay overnight for appointments. You get in there around noon, having to wait until 7 or 8 at night for someplace to stay. If the veterans are lucky, they will receive at least probably one meal down there. The next morning, at 7, they have got to give up their bed, and these guys that have got cancer or other severe disabilities are left sitting down in the lobby the biggest part of the time that they are down there, other than when they are in the appointments, in a straight-back chair.

There needs to be something done, and the VA, if they are going to take them out there, they need to take care of them and feed them. A lot of them can't afford, and I have talked to a lot of veterans that come back, that the only meal they have gotten is the one, if they were lucky, that they got while they were out there, and this is not right. The VA takes them down and they should take care of them. If they are going to take them from Beckley to Richmond, they should take care of them until they get back to Beckley.

The transportation to Salem and Durham does, DAV does and we don't really have that much problem that we do with the veterans going to Richmond.

Clarksburg, on the specialized treatment, you have got 2- to 3-months' wait. After getting into the hospital system, the appointments usually come as needed. Life-threatening treatment at the VAMC's that they go to, like Pittsburgh and the others, you have got anywhere from 6 months to a year-and-a-half wait.

The biggest problem is that if you haven't finished your appointment at Pittsburgh VAMC, then they have two buses going up there, one in the morning and the last one leaves at 2. If the veterans that ride the bus up, the VA bus, if they are not finished at 2 with their doctor's appointment or seen their doctor's appointment, then they have got to leave in order to get a ride back home, because if they missed their bus, they have got no place to stay that night, nothing, and they have got to wait until the next day,

either sitting around the lobby or whatever, in order to get back to Clarksburg.

This has been brought up several times in the last few years by service officers to Clarksburg and Pittsburgh, and up to right now, they haven't had any correction to this. They need to get a bus that maybe leaves at 4 in the evening or 5 in the evening coming back to Clarksburg. I know the cost of VA going to Richmond and to Clarksburg, or to Pittsburgh and these other places is high because they are using VA employees and having to pay overtime, and that is one of the reasons that we are having this problem up there.

Huntington VAMC, on specialty care, you have got 2 to 3 months for the first time. Specialized appointments and life-threatening, you have got anywhere from 6 months to a year.

The transportation problem, they actually don't have many at Huntington because the DAV transportation network are hauling the veterans out to the different VAMC's around and just don't have that. That is like meals. The DAV, while they are out on the road, and usually, they don't have to stay overnight because the van takes them that morning, stays there until their doctor's appointment is complete, and brings them back home. Now, travel, meals, and stuff like that, the DAV is paying for them.

The Martinsburg VAMC has got a period of 1 to 2 months, probably the best we have got in the State, for specialized treatment. Non-life-threatening problems, they have got 6 to 9 months.

I would like to talk about new veterans entering the VA health care system, the first time. It seems pretty well even around the State. You are looking at 4 to 6 months. If you have got an emergency, they will see you, but any followup treatments that you have got, you may have 4 to 6 months' wait period before you actually get in the VA system.

I would like to talk about the effects on the family members and the veterans for specialized health care. For most veterans, it is a 3- to 6-hour trip to other VAMC's to receive specialized health care and is a burden on the family and veterans physically, mentally, and financially. In most cases, it takes the family out of the picture of the veteran with no family support and family care and encouragement to help the veteran and family meet the crisis of a long stay, even a few days up to several weeks.

In most cases, the veteran goes for his first appointment. Afterwards, they will be sent back home, making up to six or more trips to the VAMC for testing and other treatment. After an operation that is needed, then another six to eight trips followup treatments or visits. Most veterans will make an average of 12 to 20 trips back and forth to that VAMC for specialized treatment. These trips can and should be cut down. The cost to VA health care is much greater and also to the veterans. They can't afford it.

Most of the facts on this here are my travel around the State, and that is fairly regular, talking to veterans, service officers, and other veterans' organization service officers. These are the facts as the veterans around this State and the service officers encounter with specialized treatment and services out at the VAMC's within this system. Thank you. I am available for questions.

Chairman ROCKEFELLER. Thank you very much.

[The prepared statement of Mr. Stafford follows:]

PREPARED STATEMENT OF JACOB STAFFORD, CHAIRMAN, STATE VETERANS' COALITION, LEGISLATIVE OFFICER, WEST VIRGINIA DISABLED AMERICAN VETERANS (DAV), AND NATIONAL DAV EXECUTIVE COMMITTEE MEMBER, OCEANA, WV

Mr. Chairman and members of the Committee:

On behalf of the West Virginia Disabled American Veterans and its Auxiliary. I am pleased to appear before you to discuss the Department of Veterans Affairs (VA) Health Care System. A system that has had many improvements made during the past few years, but with some imperfections relating to waiting time for specialized treatment at facility other than their home VA medical Centers and transportation problems getting to and from these VA facilities. With flat line budgets, not helping our veterans population of West Virginia and the nation.

Mr. Chairman, at the outset, I would like to commend you for your many years of dedicated service to West Virginia veterans and those of the nation. We appreciate and deeply value the advocacy that this committee has demonstrated on behalf of America's disabled wartime veterans'.

ADEQUATE BUDGET FOR VA HEALTH CARE AND BENEFITS

The President's budget for fiscal year (2002) recommends only $1 billion increase for all discretionary spending, that includes health care, and related programs under the Department of Veterans Affairs. The Independent Budget by the AMVETS, DAV, VFW and PVA is calling for an increase of at least $3.5 billion for discretionary spending, with a $2.66 billion increase for the Veterans Health Administration, to cover inflationary cost, wages increases, un-funded mandates of expanded service in last year's legislative session. The increase would restore certain services to acceptable levels. Without the additional funding, health care would be adversely effected for America's sick and disabled veterans.

Most problems in the VA Health Care System were created because of the 3 Years of a Flat Line Budget the VA suffered. The Veterans of America doesn't need this to happen again.

LONG WAITING PERIODS FOR SPECIALIZED SERVICE

BECKLEY VAMC: Veterans that received specialized care at Richmond, Salem and Durham VAMC's have 2½ up to 4 months waiting period for first time visits in specialty clinics at these facilities. This is a very serious problem when the veteran has a life threatening health care issue. After they get into the system at that VAMC they come as needed. Non-life threatening treatment can take up to 6 months to 1 year for an appointment.

Transportation problems: With Richmond and Durham 5 or more hour away, and Salem 2½ hours has created great problem for veterans getting to these facilities and back home. Most have low income and can't afford the extra cost of long distance travel and food cost. At Beckley the VA furnishes transportation to Richmond VAMC. Everyone has to stay overnight for appointments getting there around noon, having to wait until 7:00 or 8:00 PM that night for some place to stay. With them having to give up the room and bed at 7:00 AM. Some of these Veterans are very sick, some with cancer and other severe disabilities, left to set in a chair all day. If the veterans are lucky they will get one meal during that stay. Leaving Richmond VAMC at 1:00 PM for Beckley VAMC, arriving 6:00 to 7:00 PM that night without eating. The VA at Richmond should furnish a bag lunch for these patients. These problem didn't exist when DAV did the transportation for veterans, because the van waited for veterans to complete their appointment.

Transportation to Durham VAMC and Salem VAMC is furnished by DAV Transportation Network without most of these problems.

CLARKSBURE VAMC: Veterans has some of the same problems, Again long waiting periods for first Specialized appointments. 2 to 3 months wait. After getting in that hospital system, appointments come as needed. Non-life threatening treatments can take six (6) months and in some case up to 1½ Years.

Transportation Problems: Two (2) to three (3) hour travel time to other VAMCs The VA furnishes transportation to Pittsburgh VAMC. They have two (2) buses a day going and coming back to Clarksburg. The biggest problem is if you haven't finished with your appointment when the last bus leaves at 2 PM and you miss it. You have no place to stay that night. So most veterans, a lot of the time will not get to see their Doctor with fear of missing their ride home. Our Service Officers have informed Clarksburg and Pittsburgh many times during the last few years about this problem, with no correction.

HUNTINGTON VAMC: Waiting time take two (2) to three (3) months for first time specialized appointments. Non-life threatening appointments can take up to one (1) year.

Transportation Problems: Most transportation is made by the DAV Transportation Network for those veterans that do not have transportation or can't drive long distance's. Many of these problems are not encountered with food or having to stay over night. The DAV gives or pays for food while out on the road. Veterans are taken to the different VAMCs with the DAV vans waiting until their appointments are over before returning back to Huntington VAMC. Much less cost to VA and veterans patients!

MARTINSBURG VAMC: Waiting time one (1) to two (2) months for specialized appointments. Non-life threatening appointments six (6) to nine (9) months.

Transportation Problems: Most transportation is furnished by the DAV Transportation Network with few or no problems encountered at the other VAMCs. Again the DAV van waits for appointments to be completed before returning to Martinsburg VAMC.

NEW VETERANS ENTERING VA HEALTH CARE FOR FIRST TIME

All four (4) VAMCs in West Virginia will have a four (4) to six (6) month waiting for VA health Care in most cases, some longer. Emergency care is taken care of, with three to six months on follow up appointments.

EFFECTS ON VETERANS AND FAMILIES FOR SPECIALIZED HEALTH CARE

For most veterans the three (3) to six (6) hour trip to other VAMCs to receive specialized health care is a burden on the veteran and family members, physically, mentally and financially.

In most cases it takes the family out of the picture for the veteran, with no family support and family care and encouragement to help the family and veteran meet the crisis of a long hospital stay, of a few days or weeks.

Most cases the veteran goes for his first appointment. Afterwards, they will be sent back home. Making up to six or more trips back to that VAMC for test and other treatment, before an operation that is needed. Then another six or more trips for follow up treatments or visits. Most veterans will make an average of 12 to 20 trips back and forth to that VAMC for specialized care per medical issue.

These trips can and should be cut down. The cost to the VA health care system is much greater and also for the veterans.

The biggest problems with going to Richmond VAMC and I speak on my own case. The Doctors that you see, only stay at Richmond for six (6) months at a time for their rotation. If that doctor doesn't finish your treatment, the next doctor almost has to start over getting you the treatment you need. Again causing extra visits! I am not trying to down the Doctors I have only good things to say about them, because of the help they gave me. But way to many trip to Richmond VAMC and ten (10) months to get the operation that we all knew I needed to start with.

SUMMARY OF FACTS

In my travel around the state, talking to veterans and DAV Service Officer and other Veterans Service Organizations, Service Officers these are the facts others and myself have come up with. I have personal knowledge of veterans from each VAMC. More so at Beckley VAMC than others hospitals.

Chairman ROCKEFELLER. Luther?

STATEMENT OF LUTHER T. ENGLAND, VIETNAM VETERAN AND MILITARY RETIREE, WELCH, WV

Mr. ENGLAND. Mr. Chairman, on or about the first or second of March, I went to the VA hospital in Huntington. When I got there, I was having chest pains. So Scott, the doctor's assistant, sent me to the emergency room. The doctor in emergency sent me upstairs to the cardiac unit. There, I was under the care of Dr. Trainor and his team.

Dr. Trainor said I needed a heart catheterization, so Dr. Epling performed the cardiac catheterization on March 5. After the catheterization was performed, it was determined I had an 80 percent

blockage and would need a stint or a heart operation as soon as possible.

Dr. Pellecchia, he came to my room and said that this operation could be delayed, but to me, I needed it right then because I was going on 12 years with the operation I had done in Pittsburgh. I had a triple bypass, so it was getting pretty close.

Dr. Pellecchia said it could be delayed. He said he could schedule the surgeon at Cleveland VA hospital in 2 months and at Lexington VA hospital in 8 weeks. This is after Dr. Epling said it should be done as soon as possible.

On March 5–6, I called Charlotte Moreland and talked with her. She said she would try to get the VA to help me. This is when Dr. Pellecchia said he would send me to Cleveland or Lexington. I then said I would get the surgery done under Medicare and CHAMPUS.

Then on the 7th or 8th, Dr. Trainor came into my room and said I was discharged to go home, but Dr. Epling had already scheduled me to go to St. Mary's to have the surgery done by Dr. Mark Stuany. Donna Childers brought in some papers to sign saying the veterans' hospital would not be responsible for the bill. The VA transported me to St. Mary's on the 9th of March and I was released on the 12th of March. All followups were to be performed at the veterans' hospital.

I feel I was fortunate. Because of my retirement from the military, I had to go to the VA hospital and also have CHAMPUS insurance or Medicare Part A. There are some veterans who cannot afford it and they have to depend solely on the VA. The VA hospital does not have enough medical personnel and nurses and other personnel they need. But that was the problem I was having.

There was another man in my room with me. He had to have surgery done on his head. He had a brain tumor, a brain cancer, named Medford, and he went ahead and did the same thing I did, but now he tells me that followups were done at St. Mary's and he has a $1,800 he has got to pay out of his own pocket. So far, all I have spent is $297, but I got a bill from St. Mary's that says I owe them $1,005, so I am waiting on the results of that.

I don't know, but I think we need more nurses, just like I read in the paper where you wrote up about it. It was a very good article. That's all I have, sir.

Chairman ROCKEFELLER. Luther, thank you. That is very helpful. We do need more nurses.

Mr. ENGLAND. Yes, you wrote a good article on that. That was a very—you said the VA has the highest nurse in the United States and you said we are losing them and you said we need to get more nurses.

Chairman ROCKEFELLER. Right. That is true.

Is it Randall or Randy?

Mr. SIMS. Either one, Senator.

Chairman ROCKEFELLER. No, sir, it is either one or the other.

Mr. SIMS. Call me Randy, if you like.

Chairman ROCKEFELLER. Randy, OK.

STATEMENT OF RANDALL SIMS, VIETNAM VETERAN AND MEMBER OF PARKERSBURG DISABLED AMERICAN VETERANS (DAV) CHAPTER 32 (TESTIFYING FOR HIS FATHER, WORLD WAR II EX-PRISONER OF WAR PAUL SIMS), BELPRE, OH

Mr. SIMS. I never really prepared a statement, but I appreciate you letting me testify on the elderly care of veterans. It has been a big concern of mine with my father, with his memory loss and his wartime post-traumatic stress, and I think a lot of these nursing facilities and stuff don't quite understand the veterans' issues. So what they would do when they start acting up is they are drugging them heavier and letting them go dirty, basically, and that is what has happened.

I have found that the best solution was to bring my father home, where I had some kind of control over his health care, to make sure that he was clean and when he had these outbursts from the post-traumatic stress, of the beatings of being a POW and stuff, they could be controlled.

I was going to bring documentation from the nursing home, where we thought we had it in a file cabinet, but we have it locked up in a safe deposit box in the bank.

But not all of us want to put our parents in a nursing home. We would like to take care of them at home, and it is very hard to do. I do have to thank Huntington. They have done a real good job on Dad. Dad is a West Virginia veteran. They have helped me tremendously with him. It has taken some time, but it has worked.

The issues of getting the health care is getting to be a problem. It has been timely. Dad does not travel very well anymore. He doesn't like to travel, but we did make this trip. I have talked to them at Clarksburg and we have switched his medical care down to the Parkersburg clinic, which has done an extremely good job for him. We actually live approximately 5 miles from the Parkersburg clinic, so that is a lot easier on him than traveling 84 miles to Clarksburg. So I do think that the clinics are working, but we need more nurses in them.

Chairman ROCKEFELLER. And the difficulty with traveling comes just from a reluctance to do it?

Mr. SIMS. That, and the age and Alzheimer's. With Alzheimer's, you have to remember, they start losing their short-term memory. Now, he has worked all of his life, controlled it, and when the short-term memory is gone, then he goes back to the wartime stuff, and sometimes it does get hairy around the house. But thanks to Ms. Hill here and my wife, we have been able to contain it.

But one of the problems, even him at 100 percent, is we have to pay taxes, you have got to pay unemployment taxes, you have got to pay workman's comp, they have got to pay city taxes and stuff, and it is tough.

Now, I spoke to Clarksburg. They said they would furnish a nurse and they would pay—in Washington County, a high, they would pay $12.88 an hour, I believe it was, providing I went through one of two agencies. I called the agencies to see what they paid the girls and one was $6 and the other one was $6.50, I believe. Now, where is that other money going? That is my question. I mean, I am sure they have to pay workman's comp and stuff, too.

But for somebody that has worked all their life and saved their money for health care and then has to spend it on it, to spend taxes on it, they have already been taxed on it once.

Chairman ROCKEFELLER. Could you describe for the record and for the audience and for me what happens when somebody who is a POW prisoner in World War II, when he has a flashback, to the extent that you feel comfortable doing so. You said it kind of gets——

Mr. SIMS. Sometimes it can be comical and sometimes it can be bad. I have been shot at. I have had him in a nursing facility for, I believe it was around 15 months, where they had little buttons around the doors that they would program him for alarms. He is programmed to escape. He would stand back and watch them and then push those buttons and get out, and he was walking up and down Route 47 four different times after dark, and that scared me. I was really alarmed about that. One time, the Wood County sheriff did pick him up.

Chairman ROCKEFELLER. So, in other words, what he was——

Mr. SIMS. He was programmed to escape.

Chairman ROCKEFELLER. What he trained himself to do, so to speak, back then came back to him and he tried to do it under these circumstances.

Mr. SIMS. Right. Also, he would pound on the desk, the nurse's station and say, "I'm not a POW no more." He has done that a lot of times, and that is all documented in the medical files he has.

Chairman ROCKEFELLER. What do you do or does his nurse do in a situation like that?

Mr. SIMS. The best thing to do is to redirect him, is to just start talking about another subject and redirect him and get their attention on something else. Ms. Hill here, it is just a shame that everybody couldn't have somebody like her. She has had my father laughing harder than I think I have ever heard him laugh in my life. So things like this is the best medicine, in my book, for these people.

And not all these guys are getting good care. There is an article in this latest edition of Disabled American Veterans. A gentleman that served 32 years, 6 months, and 3 days, was a POW for 15 months and can't get any benefits. See, now these things shouldn't be happening.

I am a disabled veteran myself. If we cannot take care of the POW's, I am scared what is going to happen to me. I cannot even get insurance, health insurance, life insurance to bury me with. So we have got a problem.

And our younger generation is seeing this problem, Senator, and they do not want to go in service. My son is an Eagle Scout. He is in college now and he just said, "Dad, I just see what has happened to you and I see what happened to Grandpa and I don't want to go in service," and I really couldn't blame him, because of these cutbacks, and this current administration, it is going to ruin us.

Chairman ROCKEFELLER. Well, I don't know if it is going to ruin people, but the VA budget, as everybody here knows, unlike a regular non-VA budget, limits true national health care—you cannot go above the budget, none of the divisions of the health care system can go above the budget—so the budget defines the total system.

In the non-VA health care system, the cost of health care can rise up and people still go ahead, or insurance companies pay for it, in part. But in the VA, you can't do that.

It is interesting to sit and watch the VA system work along with the non-VA system, or the private health care system, whatever you want to call it. They both have problems. One is under a budget and one technically isn't, in the same way, but they both have problems. Health care is tough. But in the VA, if you don't have the budget, it gets a lot tougher real fast.

We discussed a little bit waiting times. Jake, I think it is probably fair to say that a number of the VA facilities don't have the personnel. They just don't have the people.

Mr. STAFFORD. Well, the problem you have got, like going to Richmond or Durham or any of these outlying specialty clinics, the thing of it is, they try to take care of their veterans there and most of them are overworked to start with. So what they have got to do is try to work this particular veteran within their health care system. Now, once that veteran gets into that clinic, then, well, your appointments come as needed.

The only thing, a lot of these people are traveling a long, long distance, OK, and if they could take, once they do their initial appointment with the guy or gal and let them—to where they know their problems, and all these tests, instead of running backward and forwards, backward and forwards, I know myself, when I was going to Richmond with my back problem, it is a terrible, terrible pain when you can't walk and you have got to sit in a pickup truck or a car, trying to get down there and back. I probably made 40 trips between Wyoming County and Richmond.

A lot of these veterans cannot do that. You have got veterans maybe with cancer, all this type stuff, and taking treatments, radiation treatments, and it is hard to go down there on those guys, especially the ones riding the VA transportation, and sit all day waiting until the next morning and they have done rode 4 or 5 or 6 hours, and wait until 6 at night, or 7, and sometimes until 8 to get a place to lay down. If they get in there early, sometimes they get a meal. But if they have to wait until 8, they have got nothing to eat unless they have got the extra money.

That is just like these veterans that we pick up with the DAV transportation program. A lot of times, we go out and pick up five, six, seven people and leave the house at 3 in the morning to get them to the hospital for the first appointment. Then all day long, you have got different ones who have got different appointments. And that is something we have tried to get them to do, is schedule their appointments for early in the morning, maybe 9 or 10. I know a lot of the clinics don't come in until evening. But those guys that are coming in the evening should be set up to start those evenings appointments because they know the ones that are riding the vans.

Most of these guys that are riding the vans, they can drive a little bit around home, maybe to run to the store or get groceries or what have you, but they just are not able to drive the distance to Beckley, and if they have to hire somebody to take them, they want a miner's wages or whatever and it takes away from food or paying the electric bill or something like that that they may have.

The last 3 years, the transportation program in West Virginia is probably the best in the Nation, with the help of the State legislature. We have gone over a million miles and something like nearly 50,000 volunteer hours and hauling 27,000, 28,000 veterans a year. I shouldn't say veterans, I should say appointments because some of them, more than one.

Chairman ROCKEFELLER. Do any of the others of you have comments on that question of transportation? Of course, if there isn't an outpatient clinic or if the outpatient clinic doesn't provide the care for that particular problem, you have to travel. Randy, I know you have been down to Salem a lot and other places. In other words, you could argue that that is the only way you are going to get the specialty care, but if you have to get to someplace where the care is offered, you have to take transportation. You are saying that transportation is hard on people, and some kinds of people in particular because of their health problems. But is there a way around that? I don't know the way around that right now.

Mr. PLEVA. You know, to be honest with you, Senator, I don't see a way around it, just like if our people, if we don't drive ourselves or a family member takes us, unless the VA would pay for the transportation down to Richmond and back.

Another concern that we had, also, when I was in Clarksburg talking about these CBOC's, these clinics, when an SCI person goes in and doesn't have the transportation to get to Clarksburg or to one of the four main hospitals, what type of transportation needs do you have there, just as the DAV does not have lifts in their vans for wheelchair people. So they are either going for a family member or a friend to drive them or they sit at home, and this is one of our great concerns.

Chairman ROCKEFELLER. And that is not taking the chance to go to where you need to go.

Mr. PLEVA. Right.

Chairman ROCKEFELLER. So, on the one hand, you have an uncomfortable transportation situation, more so for some than for others, but on a net basis, it is more important to get to that care, isn't it?

Mr. PLEVA. Yes, it is, but there is not a middle-of-the-road here. It is either it happens or it doesn't, and a lot of times, sir, it doesn't happen.

Chairman ROCKEFELLER. Does that tie into what you said before about people not getting checkups, or is it that people in West Virginia sometimes just don't want to travel to another State or long distances, they just don't want to do that but they do have a need to do it?

Mr. PLEVA. Yes. Yes. And honestly, now that we have the SCI primary care teams, and probably if you would ask Mr. Pennington or people like this, directors of these hospitals, these guys are so used of getting their SCI care at the hospitals here in Huntington, Martinsburg, Beckley, Clarksburg, that they feel like these hospitals should provide this service, which some of them may be able to provide the whole service, but some of them cannot and they don't want to leave Huntington. They don't want to leave the State. They say, "Well, why can't you do it here? You have people who

know about spinal cord injury health care," and so on. But some things need to be done in Richmond and they just refuse to go.

Chairman ROCKEFELLER. That is interesting. You are talking about human nature, aren't you?

Mr. PLEVA. Oh, absolutely.

Chairman ROCKEFELLER. If you have a really good specialty spinal cord injury physician or health care team in a place which is not near, you have got to go to it.

Mr. PLEVA. Yes, you do.

Chairman ROCKEFELLER. But you are saying that they won't go to it even when they get that level four or five, or that is the only time they do go to it?

Mr. PLEVA. That is when they will go to it.

Chairman ROCKEFELLER. That is when they will do it.

Mr. PLEVA. When everything else has stopped, you know, when everything has gave up, then yes, you know, you had better go or you are going to lose your life, just that simple.

Chairman ROCKEFELLER. Can you give me an example, Randy, of a time when it doesn't reach that level of drama but when you would say to somebody who is very familiar with this that they ought to go, even if it is not that convenient?

Mr. PLEVA. Oh, well, we deal with that every day.

Chairman ROCKEFELLER. Give me an example.

Mr. PLEVA. We have people that need to get tests done on their bladder, things of this nature, and we will even work with the SCI coordinator at the different hospitals and we will get calls, "Hey, I want you to talk to this person and see if they won't go to Richmond." And as soon as you go in the room, they say, "Why do I have to go to Richmond when they can do it right here?" But if they can't do it here, you need to go.

Like I said, this is an every day—not every day, but it is something that we deal with constantly, trying to get them to go—and also, it is also not only for transportation problems but due to the care that they receive in these SCI centers is not the best care in the world. That is something else that needs to be looked at, also, which I discussed a little bit, to your attention.

So, yes, they are here in the State of West Virginia, and no, they don't want to leave Huntington or whatever, but even though the director or the SCI coordinator or doctor goes and tells them they have to go to Richmond, some of them just plumb refuse to go.

Chairman ROCKEFELLER. Yes. It is a little bit like flood insurance, isn't it?

Mr. PLEVA. Really. [Laughter.]

Chairman ROCKEFELLER. I mean, somebody can be flooded out five times, but they will go right back and they won't get flood insurance. You would think it would be pretty obvious that people want to get flood insurance, but they don't. What you are dealing with is human nature.

Mr. PLEVA. Right. And the other side of the coin is this. This is why they are trusting the VA now, because now you get them into Huntington, where before, they would not even go to the VA. But now you are getting them into these four VA hospitals or into the clinic, so it is going to take time to get them to go into the SCI centers.

Chairman ROCKEFELLER. OK. Randy, another question for you, since I have just got you on the list here. You have fought for a long time for veterans with spinal cord injuries, I mean, for years and years and years that you and I have known each other. There have been some eligibility reform changes. The network system has changed. Community clinics have changed. Transfers, we have already talked about, have increased. But what has been the effect of some of these other changes on veterans with spinal cord injuries?

Mr. PLEVA. Again, as I stated earlier, the trust in the VA system, once again, like I said, these primary teams, these SCI primary care teams. At least they can go in and someone knows what they are talking about, where 8 years ago, they didn't unless they were at an SCI center somewhere. But here in the State of West Virginia, all four SCI primary care teams are up and running. People know what their problems are, and that is one of the big breaks that this State got, I will be quite honest with you. Along with eligibility, all different categories now, we are not in this five or six or seven. The non-service-connected is treated the same as the service-connected. There is no ifs, ands any longer when you go to these teams.

So there is a plus here for that. Like I said, is it one that is going to come back and bite us on the rear end later on? I really don't think so, because you have good men and women at the VA that are dedicated. But like Jake said, you know, and everyone on this panel, these people are worked to death. They are wearing, like, six different hats. So they may be SCI coordinator one day, which they will be, but they may be over another department the next day.

That is why, again, I go with the training on the floor for nurses and aides, that whole thing with the turnover, where nurses are on the floor for so long and then they are off the floor, they are working somewhere else, so you have whole brand new nurses come on and they don't have the foggiest idea about how care is done.

But, yes, I really honestly believe that the primary care teams have boosted. I believe it has saved a lot of lives in this State.

Chairman ROCKEFELLER. I appreciate that.

Jake, on the transfer situation, we really discussed that, but is there anything that we can do that makes transfers work better, easier, something?

Mr. STAFFORD. Yes. The biggest thing is the number of trips that they have got to make between their own VAMC and one of the specialty clinics. They could take—I know that the VA went from inpatient to outpatient. I think it saved a lot of money and it was good.

But on these specialty clinics, like going to Richmond, they can take those people, and that is their initial appointment down there, and the doctors know basically what needs to be done or maybe should be done, instead of making 8 or 10, 12, or 15 trips back and forth between that VAMC, they can put them in the hospital for a couple days and do these tests. Now, it may be depending on the condition of the veteran, but it could happen, and that would save the VA a lot of cost. It would save a lot of cost to the veterans and

all the way around make it better and not have near as much painful sitting in those vans.

That is just like if you go from Beckley to Richmond as a wheelchair patient, you sit in your wheelchair the 5-hours going to Richmond. Then you have got to stay down there all night, and then there again, you are sitting all day, and you done traveled those 5 or 6 hours. They need to do something to take care of these, because what they do, the van goes down. It gets there about 12, and at 1, it leaves to come back to Beckley. So that means everybody has got to stay overnight.

When the DAV did the transportation between Beckley and Richmond, they took them down that morning, they go to their doctor's appointment, and when everybody finished up, then they brought them back to Beckley. But right now, the cost of paying the overtime and the employees there at Beckley, we have had a lot of problems about the cost of the van program.

Well, I mean, if you do things to increase it, and that is not counting the extra cost that Richmond has got of keeping these guys overnight, and the reason they don't furnish more meals than they do is because they are looking at costs, and they shouldn't be looking at costs. They should be looking at what is best for that veteran.

But that is just like I said on getting from home to there. I mean, these volunteer drivers, and it is not just DAV people, it is VFW, American Legion, and a lot of them come in there and help with that program, and they should be commended because, like I say, some of them are up at 3 in the morning, get everybody there maybe by 7, and at 4 in the evening, you get finished up and you are until 7 or 8 at night getting back home.

Chairman ROCKEFELLER. Randy—Luther, I am not skipping over you again—Randy, you were talking about that you weren't necessarily in favor of putting your father in a community nursing home, that you would rather take care of him at home. Now, I know about taking care of somebody at home. My mother died from Alzheimer's. Actually, you don't die from Alzheimer's, you die from your lungs filling up, but it is a result of that. We had her at home because we could afford to do that and to get her the kind of care that Vera provides. But talk to me a little bit about why the community nursing home isn't the kind of solution that you want to see.

Mr. SIMS. Mr. Chairman, the community nursing home, they are out to make a profit like everybody else. You may have one girl trying to take care of 20 patients in an 8-hour shift or something, and they are just running around. They can hardly keep up with their work. They don't have the time to invest in that patient to take the proper care of him, so they end up over-medicating them, having a house doctor come in and over-medicating them just to keep them quiet and down.

Chairman ROCKEFELLER. One hears about that, right, over-medicating just for the sake of not having a problem?

Mr. SIMS. To keep them out of trouble, yes, sir. The first thing I did, we cut my father's medication in half, and then I would have to ask my wife on this. I believe the doctor down in Parkersburg

cut it again, didn't he, and things have been manageable at the house with just redirection.

Chairman ROCKEFELLER. So you are just more in control of the situation?

Mr. SIMS. Right.

Chairman ROCKEFELLER. You feel better—as a son, you feel better psychologically, having your father right at home.

Mr. SIMS. Yes. You can't just put him in there and go see him and see him the way they take care of him. It is terrible. And it is not just one. I am not depicting on one personal care home or nursing home, because I checked around to several of them and they are pretty much all the same. They hire young girls that don't have much experience. They are learning.

Chairman ROCKEFELLER. Yes, and it is hard to blame them, because if you have got 20 patients to take care of, it is difficult. We had some VA nurses up in Washington describing what it was like after 16 or 17 hours straight on duty. You just sort of begin to lose that edge, and in some cases, that sense of compassion or concern. I mean, again, it is a matter of human nature.

Mr. SIMS. Exactly. You have got to do best for your parents, you know. You just try to do what you can do.

Chairman ROCKEFELLER. Isn't there also something in your father knowing Vera, that he sees her on a constant basis, the same person?

Mr. SIMS. We got Dad out of the home January 27, and that is when, I believe, we hired Vera, the same day. She has been with us since then.

Chairman ROCKEFELLER. Yes, and that continuity helps, doesn't it?

Mr. SIMS. Yes, the continuity really helps.

Chairman ROCKEFELLER. It calms your father down?

Mr. SIMS. Yes. It makes it easier for her to redirect him, and if you have different girls coming in all the time, it is more confusion for somebody with the memory loss.

Chairman ROCKEFELLER. Yes. Yes. I appreciate that.

Luther, you faced a lot of frustration and, I would guess, a lot of anxiety in getting that referral for your heart surgery.

Mr. ENGLAND. Right.

Chairman ROCKEFELLER. There really wasn't anybody who was going to tell you what to do on that occasion, were they? I mean, you were determined. You had been through it before. You weren't going to mess around and you weren't going to wait, and when you had an opportunity not to wait, you took it. Now, how does this happen in a VA hospital? They might not have told you that you could wait—I don't know this, as I said—but they might not have told you that they could wait because they felt that you should wait, but because they couldn't really do anything about it right then, because the caseload had stacked up. What is your analysis of that?

Mr. ENGLAND. Well, that is what I got, is that they couldn't get me in Cleveland or down to Lexington. They couldn't get me into the operating room or to get it done. In other words, I am going to have to wait at least 8 weeks before they could get me there.

Chairman ROCKEFELLER. So you did not really need a lot of analysis. It was just the words "8 weeks." That is about all you had to hear.

Mr. ENGLAND. In 1988, I had my operation, same time, same period about it. It was the first of March. Brenda Peter, she was the doctor for me at that time. She wanted to send me right up to Pittsburgh to get my triple bypass, but, you know, I was kind of scared, so I told her, "Let me go home," and she let me go home. But she called me every day in the morning, in the evening. She would either have the nurse call me or Cathy, I think it was Kay, and told me, "Get back to the hospital."

So I got back there on the 10th of March and she sent me straight up to the hospital. I mean, there wasn't no waiting about it. And I got up there in Pittsburgh and I thought, well, there will be waiting around. I was there 3 days. On the 17th of March, I think it was, or somewhere around there, they operated on me. The doctor comes in and says, "We are going to operate on you," 1 day, and the next day, I am in the operating room. That is how fast it was.

And here it is, the same time, the same period, and I am thinking, hey, are they going to let me just hang around here and die or something? It is on your mind. So I decided I would go ahead and go to St. Mary's.

Chairman ROCKEFELLER. Now, back in the 1980's when you had care, the VA did transfer you, didn't they?

Mr. ENGLAND. Right, but I went home and then they brought me back. I came back. The doctor kept insisting I come from my house back to the VA. When I got here, they were sitting there with my records and put me in a car and they didn't wait. They just drove me straight to Pittsburgh. And when I got to Pittsburgh, I thought it would be a few minutes. I was in the room in less than an hour.

Chairman ROCKEFELLER. You know, one of the things that this panel tells me again is that so much is the way you are treated. Waiting times get turned into "how much do they care"-type situations. In other words, a great deal of it is, as I keep saying, just human nature. If you are waiting, and if you think you need something and you are not getting it, you just start worrying. And once you start worrying, there is not much that is going to get you off that track until something happens.

I think this is going to be one of the great challenges of these next couple of years without adequate funding: how are we going to make up for this and how we are going to handle this? We had a hearing in Washington, as I said on VA nurses. They came in and they testified that they were working 15, 16, 17 hours on mandatory overtime. It raised very interesting questions. They wanted us to take away the mandatory overtime, and I am somewhat sympathetic with that.

But if you are the veteran that is being looked at and there is either going to be a nurse or there isn't, you have to have a nurse. And if there is a nursing shortage and if it is going to get worse, this is critical, isn't it? That nurse often, as much or more than the doctor—maybe usually more than the doctor—is the person who gives you a sense of, "I am on my way to getting some help," or "I am not on my way to getting some help." Isn't that right?

Mr. ENGLAND. That is right. Just like you wrote in the article about nursing, we are going to lose a lot of nursing. In fact, I think I had a friend, she just retired from the VA up there and she went to Florida. She ran two of these outpatient clinics and she was really good. Now that she is gone, I don't know who is taking her place, but we have got to have people to take her place.

Chairman ROCKEFELLER. What was interesting, and I will conclude on this with this panel, and I will thank you in a minute, was that VA nurses actually have a longer duration of service than do nurses in general. I think they said they averaged 27 years of service, which is really a long time under a tremendous amount of pressure, and a tremendous amount of emotional wear and tear on them.

But we have got to face it. Nurses are like teachers. They can go off to a private hospital and make more. And you can say, well, they ought to stay with Randy or Jake or Luther or Randy's father, but when somebody gets offered $10,000, $15,000, $20,000 more per year and they have got children, that is a tough call for them to make, right? Obviously, a lot of them are making the call to stay in the VA system. But the question comes, when they retire, about what the next generation of nurses is going to do. That is what I think we have got to worry about, and that is where pay comes in, which is where money comes in.

You can wish that a nurse were on a corridor, but unless you have got the money to pay that nurse to be on a corridor, that isn't going to happen. So people can say, well, the Federal Government, they just take money and throw it away. If you are paying a nurse, you are not throwing money away. You are giving a whole series of veterans a sense of continuity and trust and care that you can't do any other way.

The Red Cross doesn't come in or the Salvation Army doesn't come in and say, "We are going to supply you with nurses." Either the government is going to do it or nobody is going to do it, so the money has got to be there.

Yes, sir?

Mr. STAFFORD. I have got one more thing I would like to talk about and that is a lot of your rural VA hospitals like Beckley, and the others we have got in West Virginia, they are trying to replace doctors with physicians' assistants. I am not trying to put the physicians' assistants down. They have got a 4-year bachelor's degree. They have got 2 years of regular academics and 2 years of practicing.

If I had to go to a VA hospital, I would rather have a 4-year-trained RN than I would. Now, I am not saying that in the future, they are not going to get better. But their anatomy studies is not near what a doctor is. You know, you are looking at 6 years of schooling to be a doctor. But they try to make doctors out of these physicians' assistants, and why? In order to save money. They would rather give them $50,000 or $60,000 a year as $120,000 a year to a doctor. That is the biggest problem we have got in a rural-type settings with the VAMC's.

Chairman ROCKEFELLER. Well, you have got that, and let me give a little bit of the other side of it, and that is that we have got to find out a way—I have said this many times before. I can re-

member going to the Yale Medical School back in the late 1980's, just because I wanted to. I had a friend up there who was the Chairman of Psychiatry and I said, I want to get everybody in medical care, everybody who is training to be something—doctor, nurse, physician's assistant, whatever—I want to get them in this room and talk with them. The administration is OK, but they have got to sit at the back. I don't want to see them. I want to talk to these others. And he did it.

And what was amazing to me then—and, of course, that was then—was that the doctors who were trained to be doctors never interacted or crossed paths with the nurses who were trained to be nurses. Those two groups were obviously going to be working together for the rest of their lives. Everybody was kind of just on their own track.

And I think one of the things that is going to be part of our health care future in this country is that there is going to be more of a cross-relationship in a constructive way between various parts of the health care community because there is going to have to be. I understand what you are saying about the physicians' assistants, and I remember there were some people, including myself at one point when I was Governor, who were not sure about them. We had three medical schools in West Virginia, one of them here, one at WVU, and then the osteopathic, and I didn't think we could afford three.

Well, we can't afford three, and so I made a move to do something with the osteopathic school, which I now regard as one of the larger mistakes of my life. Those folks may not be everything everybody wants, but they are turning up in little towns and communities all over Southern West Virginia and the rest of West Virginia and I really like that. In other words, they go to these rural places and they stay there and they stay in our State. I am not saying that Marshall and WVU graduates don't. They do, too.

But this is part, I think, of our health care future, where you are going to get these mixes of people working together to solve a problem because there just aren't enough staff. My 21-year-old—well, he is 22 now, actually, as of a couple of days ago—he wanted to be a doctor at one point and he spent 2 weeks at Georgetown Hospital in Washington. That was really a program. They locked him in. He couldn't step outside Georgetown, and he got to see everything. I mean, he went into OR and to ER. He saw the whole thing for 2 weeks.

What was amazing to me was that half the doctors informally counseled him not to go into medicine because, they said, the pressures are so tough. It kills your family life and everything else.

When you have really good times, like we did in the past 8 or 10 years or so, then people get siphoned off into other areas. Now we are maybe not going to have as good a time for a few years economically so people will stay where they are more, but it is a problem. It is just a problem.

Those nurses who are working 16 hours a day can't keep doing that. You just can't do that and provide the service, and keep yourself on track. You can't do it.

So there is a lot we have got to figure out about how to make health care work both in the VA system and outside of it, and I

want to really thank each one of you because you are each facing different kinds of problems and situations and you have all been fighters for veterans and I really, really appreciate your taking the time to come here this morning. Thank you very, very much.

If panel two could come forward, that would be David Pennington, John Dandridge, John Looney, and Becky Fox.

You have heard about people who go by the book. I am going to go by the book, so John, I am not going to start with you because you are not first on my list here, so you have to wait until you turn up on my list. I am going to start with David Pennington, who is Director of the Huntington VA Medical Center. David, I am really glad that you are here.

What I guess I will do is I will introduce each of you and then I will have a series of questions for you. Now, we didn't use those lights for the veterans. I have never much liked those lights because they are kind of rude because they sit right in your face. They probably ought to be sitting here instead. But, nevertheless, that is just to kind of make sure we get to ask questions and that kind of thing and that you get to say what you want to say after the testimony. Your testimony is always included.

Incidentally, in your case, we will also have some followup questions because we did not get some of the testimony until late. So we will have more questions than the ones that I ask.

The second witness is John Dandridge, Jr., who is Director of the MidSouth Health Care Network, which is otherwise called VISN 9. That means you direct medical centers in Huntington, Lexington, Louisville, Memphis, Mountain Home—where is that?

Mr. DANDRIDGE. That is in Johnson City, TN.

Chairman ROCKEFELLER. Johnson City, TN, Murfreesboro, and Nashville.

Mr. DANDRIDGE. Correct.

Chairman ROCKEFELLER. So you have got a bunch of hospitals.

Mr. DANDRIDGE. That, I do.

Chairman ROCKEFELLER. And this is your first job with the VA, isn't it?

Mr. DANDRIDGE. That is correct. I have been with the VA—it was 3 years in June.

Chairman ROCKEFELLER. That is good. And you had how many years of experience before that?

Mr. DANDRIDGE. Twenty years.

Chairman ROCKEFELLER. Twenty years of non-VA health care experience before that.

Mr. DANDRIDGE. Correct.

Chairman ROCKEFELLER. The next fellow here is named John Looney, who I have known for a couple of years. John is the Team Leader up at the Wheeling Vet Center. John, you also testified in 1993.

Mr. LOONEY. Yes.

Chairman ROCKEFELLER. 1993—that seems like a long time ago, but you testified and I appreciate that, and you have been a friend a long time. You talked about the role of the Wheeling Vet Center then. It seems to me like we didn't open that up until after 1993, but we obviously did.

Mr. LOONEY. It was 1990.

Chairman ROCKEFELLER. It just doesn't seem that long ago to me, but you are right. And you are going to talk a little bit about what you hear from veterans in terms of the Northern Panhandle and the vet center, also Pittsburgh, because you use Pittsburgh. That is your——

Mr. DANDRIDGE. Right. That is our hospital.

Chairman ROCKEFELLER. That is your hospital.

Becky Fox, more formally known as Rebecca, is the Clinical Support Manager for the Mid-Atlantic Network, VISN 6, and that is made up of eight VA centers and that is Beckley, Ashville, Durham, Fayetteville, and Salisbury in North Carolina, and Hampton, Richmond, and Salem in Virginia.

Ms. FOX. Correct.

Chairman ROCKEFELLER. So you move around some.

Ms. FOX. We sure do.

Chairman ROCKEFELLER. One of the reasons, obviously, that we got the both of you was this question of people going back and forth and spinal cord injury and all the rest of it.

But now let me be quiet, and John, why don't we start with you.

STATEMENT OF JOHN LOONEY, TEAM LEADER, WHEELING VET CENTER, DEPARTMENT OF VETERANS AFFAIRS, WHEELING, WV

Mr. DANDRIDGE. In the interest of time, I would like to submit my statement in writing——

Chairman ROCKEFELLER. All your submissions are accepted, for everybody.

Mr. DANDRIDGE [continuing]. And just highlight a couple things.

One, I see the vet center as the front door to the VA. We get questions from veterans concerning their claims, as well as health care, and also the tele-psychiatry which we worked so hard to get. Your office was instrumental in getting that set up for us. It is very successful. We have 8 to 12 different veterans using that facility each month and we are real pleased with how well it works. We also had dermatology working on it. It has really helped the veterans become medication compliant and it has done very well. We really appreciate that.

Chairman ROCKEFELLER. And you do PTSD over there, too, don't you?

Mr. LOONEY. Correct.

Chairman ROCKEFELLER. When we get to questions, I am going to ask you about that because that interests me, what kind of setting, how important is the setting for doing correct PTSD, No. 1, and second, how important is it to treat a number of veterans together for PTSD as opposed to working with one or two individual veterans. Do veterans leverage each other to let it come out some?

[The prepared statement of Mr. Looney follows:]

PREPARED STATEMENT OF JOHN LOONEY, TEAM LEADER, WHEELING VET CENTER, DEPARTMENT OF VETERANS AFFAIRS, WHEELING, WV

Mr. Chairman and members of the Committee:

I am pleased to appear today at this field hearing of the Senate Committee on Veterans' Affairs. Readjustment Counseling Services (RCS), or Vet Centers, are community-based operations of the Department of Veterans Affairs (VA). As part of the Veterans Health Administration's mission, the Vet Center program provides

psychotherapy to combat traumatized veterans. Vet Centers also refer and coordinate veterans' care with VA medical centers (VAMCs). I like to refer to Vet Centers as VA's front door. Vet Center staff members both explain hospital procedures to the veteran and relay the veteran's concerns to the hospital staff. RCS sees this as part of our mission.

I believe it inevitable that misunderstandings will happen between client and staff of any medical system. I feel a great sense of accomplishment when a combat veteran in his seventies or eighties comes back to me and says: "That fellow you told me to call at the VA Hospital did a wonderful job for me".

The Wheeling Vet Center is only a three-person team, yet we have provided 1,311 veteran contact hours since January. Between the other therapist, Jay Teacoach, and myself, we see 12 veterans per workday. We refer over 80 veterans annually to the VAMCs for inpatient services. The Wheeling Vet Center has received a grant from the Retired Non-Commission Officer Association to work with the Wheeling area Soup Kitchen to serve homeless veterans a special meal on the 4th of July and Veterans' Day. We have also received a gift of money from a local Martial Art Tournament allowing us to sponsor a 2-bus pilgrimage of veterans to the Korean, Vietnam, and Women's Memorials in Washington, DC. This one-day trip will be comprised of several generations sharing their remembrances of friends and sacrifices made to ensure freedom and democracy. VA headquarters is exploring documenting this pilgrimage of Upper Ohio Valley veterans.

Mr. Chairman, I know that you are an advocate of coordinating care through telepsychiatry for veterans living a 2- to 3-hour drive from the VA Hospital. Currently 8 to 12 different veterans are seen monthly at our Vet Center for medication checks with their psychiatrist via tele-health.

Mr. Chairman, this concludes my statement. I will now be happy to respond to any questions you may have.

Chairman ROCKEFELLER. David, you have got actually 2 extra minutes from John. [Laughter.]

STATEMENT OF DAVID PENNINGTON, DIRECTOR, HUNTINGTON VA MEDICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS, HUNTINGTON, WV

Mr. PENNINGTON. In the interest of brevity, Senator, I will take only a few minutes. Since testimony has been submitted, I would just like to highlight a few things on behalf of Huntington and its system of clinics and say how pleased I am to be here today to have the opportunity to chat with you and others.

There have been a number of important topics here already presented, issues that both John and I have worked diligently with, and I am sure Becky, as well, in her Network. But I would just like to highlight a few things in regards to Huntington.

We have a very proud history of serving veterans with a little over 700 employees and 80 inpatient beds. We are following the trend of health care and have moved most certainly into the outpatient arena. We are a little different than the other three sites within the State in that we have a little more depth in regards to our sub-specialty care, and working with Joan C. Edwards School of Medicine at Marshall, have been very fortunate in our recruitment efforts. We have, in addition to our cardiology, the opportunity to do diagnostic caths as well as electro-physiology studies. We have some depth in orthopedics, pulmonology and gastroenterology, chronic pain management, acute dialysis, neurology, and some other areas. Most of this is reflective of our working relationship with Marshall, and, of course, as you well know, Marshall's basic science building sits on the campus with the VA.

Chairman ROCKEFELLER. And that is the reason, you think the basic reason, that you are able to get these specialties and sub-specialties?

Mr. PENNINGTON. I think that has a lot to do with it, as well as a tremendous working relationship with the Dean, Charlie McKown. Charlie and I meet on a weekly basis, and he and I are both very interested in regards to what we can do collectively in serving veterans.

Last year, we provided care for almost 23,000 veterans. You made mention of the fact that the river is an artificial boundary, and we take care of veterans in Southwestern West Virginia, Eastern Kentucky, and Southern Ohio. For the last 5 years, we have seen tremendous growth, from approximately 17,675 veterans to a projection of 23,000 for this year. That certainly comes with its challenges, and as you well know, in Appalachia, there are many challenges in regards to providing healthcare services.

We have been very fortunate in our support from the Network in regards to opening community-based clinics. Of course, we have one in Charleston which is VA staffed and operated, as well as Prestonsburg, KY. A contract clinic just opened last week in Whitesburg, KY. We are working diligently on one in Mingo County, in addition to our one in Logan, which is in operation.

Indeed, we do depend on other medical facilities for our tertiary-level care, primarily Lexington and Cleveland VAMC's. Last year, we transferred 196 patients to other facilities for care. Some of those services that we do not provide locally at Huntington are inpatient psychiatric care, open heart surgery, and some orthopedic surgery—joint replacement. We work with VISN 6 in regards to Richmond VAMC for spinal cord injury and traumatic brain injury, but most of our referrals go to Lexington or Cleveland. Occasionally, we do use Nashville in regards to some very sophisticated care needs. Our objective is to get the veteran to the best place that they can be treated in a timely manner.

We do a number of things in relationship——

Chairman ROCKEFELLER. How long does it take? I have never driven to either Cleveland or Nashville.

Mr. PENNINGTON. Nashville—I hate to tell you how fast I can drive it, Senator, but it is about a 6-hour trip from Huntington.

Chairman ROCKEFELLER. And what about Cleveland?

Mr. PENNINGTON. Cleveland is about a 4½- to 5-hour drive.

Cleveland has provided our veterans excellent service and quality service, and we are a part of their major teaching program in cardiac care. Lexington, being the closer facility to us for tertiary-level care, is the facility we try most to get folks to when needed.

Senator that will conclude my comments and I would be happy to answer any questions you may have.

Chairman ROCKEFELLER. OK. David, I appreciate that very much.

[The prepared statement of Mr. Pennington follows:]

PREPARED STATEMENT OF DAVID PENNINGTON, DIRECTOR, HUNTINGTON VA MEDICAL CENTER, DEPARTMENT OF VETERANS AFFAIRS, HUNTINGTON, WV

Mr. Chairman:

It is a pleasure to be here today to speak to the Senate Veterans Affairs Committee regarding issues of access to, and quality of VA health care in a rural setting. As Director for the Huntington VA Medical Center (VAMC), it is truly an honor to provide you and the Committee with a brief outline of the Huntington VA Medical Center and the services provided our patients.

The medical center has a proud history of serving veterans. With a dedicated staff of just over 700 employees and an operating budget over $78 million, the Huntington VAMC operates 80 medical and surgical beds, an inpatient and outpatient surgery program, and an expanding outpatient treatment program. Huntington VAMC has the good fortune of being able to recruit quality subspecialists, in part due to our close affiliation with the Joan C. Edwards School of Medicine at Marshall University. Medical subspecialty care provided at the medical center includes cardiology (including heart catheterization), electrophysiology studies, orthopedics, pulmonology, gastroenterology, oncology, ENT, nuclear medicine, neurology, acute dialysis, chronic pain management and many other subspecialties.

Huntington VAMC has undergone not only a physical transformation but also a clinical one, which has improved the quality of care for more veterans. Working with the Joan C. Edwards School of Medicine, the VAMC has increased clinical services, expanded access, and improved the overall quality of care to veterans. We are striving to be a customer-focused organization with a goal of being the veterans' provider of choice.

Medical students and residents train in an atmosphere of modern medicine. What was once a 250-bed facility with limited subspecialty care and outpatient services is now an 80-bed facility with a much larger outpatient program, designed to treat patients in a comfortable and friendly environment. During fiscal year 2000, there were over 181,000 outpatient visits for Huntington VAMC.

Huntington VAMC provides quality medical care for almost 23,000 patients in southwestern West Virginia, eastern Kentucky, and southern Ohio. The number of veterans choosing the Huntington VAMC as their primary healthcare provider has increased significantly over the last 5 years, from 17,675 in FY 1997 to a projected 23,000 in FY 2001. This increase can be attributed to our quality of care, customer service, expanded range of services, and greater access.

Convenient access to healthcare for veterans in Appalachia has been a critical issue, and the VAMC and Network 9 have worked diligently to address this need. The DAV transportation program has filled a tremendous void for many veterans by building a network of volunteer drivers and a fleet of vehicles. The establishment of community-based outpatient clinics (CBOCs) is another initiative for improving access. In 1998 Huntington VAMC opened a VA-staffed CBOC in Charleston. This clinic provides improved access for many veterans, including those in surrounding counties such as Boone and Jackson. This year, we opened a contract CBOC in Logan County, and before the end of the year we expect to open another contract CBOC in Mingo County. We also operate a VA-staffed clinic in Prestonsburg, KY and have just opened a contract clinic in Whitesburg, KY. During the 3-year evaluation and study period, each contract clinic will have a limited enrollment of 600 patients.

VA health care relies on a system of support from other VAMCs. We utilize other medical centers within our Network for services unavailable at Huntington VAMC and have transferred 196 patients to other VAMCs for care. Examples of cases that are transferred to other facilities include inpatient psychiatric care, open-heart surgery, placement of stints, and some orthopedic surgery. We utilize Richmond VAMC for specialty care in Spinal Cord Injury (SCI) and Traumatic Brain Injury JBI). This fiscal year, we also have transferred 58 patients to community hospitals and received transfers of 150 patients from community hospitals.

Local inpatient and medical subspecialty care is purchased within the community when the patient's medical condition warrants emergent access to care we can not provide at the Huntington VAMC and it is not practical to transfer the patient to a tertiary VAMC that supports us. In FY 2000, 154 patients were admitted to community hospitals at a cost exceeding $1.1 million. As we expanded primary care services to Charleston, WV and Prestonsburg, KY, we have seen an increase of community hospital care in those localities. With further expansion to Logan, Williamson, and other communities, we anticipate that reliance on local community hospitals will increase for veterans who have emergent needs.

We have emphasized in our planning the provision of consistent standards as part of the expansion of community based primary care services. In order to ensure that providers at each CBOC have ready access to a patient's medical information, we have expanded our computerized patient record system to all clinic sites. Providers, whether at a VA staffed or a contract CBOC, have access to the entire medical document and can order subspecialty consults, lab tests, and radiology procedures as if they were at the VAMC. A physician, nurse, and quality management officer conduct periodic site reviews to ensure the standard of care is equal to the standards set at the medical center. Through the electronic medical record, provider-specific data are obtained to monitor adherence to quality performance measures. In addition to our own extensive quality management program, outside reviews by the

West Virginia Medical Institute (which is under national contract with VA) are conducted monthly, reviewing current medical records against approximately 32 standard of care criteria.

The VA Regional Office in Huntington, the Vet Centers, and each of the four West Virginia VAMCs have an excellent working relationship, combining planning efforts to address issues within the state. Though organizationally each of the VAMCs are aligned with a different Network, the senior management teams of each medical center meet periodically. They maintain a good working relationship and work closely to meet the needs of our patients. For example, Huntington utilizes the PTSID inpatient program at Clarksburg VAMC to minimize travel distance for patients and their families. Huntington VAMC has provided surgical support for patients from Beckley in the past, and the medical center, regional office, and Vet Center have jointly coordinated a number of veteran standdowns and participated in many veteran organization programs.

Long-term care is clearly a significant issue for our patients. The West Virginia Veterans Home in Barboursville, which provides domiciliary care, and Huntington VAMC have worked together to foster an excellent relationship geared towards meeting the needs veterans. In fiscal year 2000 there were 106 admissions to the State Veterans Home in Barboursville.

Similar to other VAMCs, we utilize community-based nursing home care services. In fiscal year 2000, 207 patients were discharged to or placed in a community nursing home from Huntington VAMC. This allows the veterans to stay closer to their homes, and closer to their families and friends. Contracting in the community has proven to be the best means of providing these services. As the veteran population increases in age, the demand for long-term care services, including geriatric psychiatric care, will increase.

Mental health services for our patients are provided on an outpatient basis at the medical center. When inpatient mental health services are required, patient care is coordinated through our system of VA facilities. Lexington, Chillicothe, and Clarksburg VAMCs are 3 nearby facilities providing inpatient mental health care. To ensure continuity of care, the Huntington staff addresses follow-up care for patients as they are discharged from the inpatient facility.

Huntington VAMC was the first facility in the nation to develop a program with our Vet Centers to conduct telemedicine for mental health counseling. Through this initiative, patients in Charleston and Logan, WV, have quicker and more convenient access to services. We have now expanded telemedicine capability and conduct subspecialty consults for neurosurgery with Lexington VAMC and will expand the system further in the very near future to include linkage with our Prestonsburg CBOC.

The VAMC provides services for homeless veterans through the Health Care for Homeless Veterans (HCHV) Program. The program was reviewed by the Commission on Accreditation of Rehabilitation Facilities (CARF), a national accreditation program, in April 2000 and was given a three-year accreditation with no recommendations, which was an outstanding achievement by our program. Two outreach social workers, a clerk, and a Team Leader, staff the program.

The homeless outreach social workers are physically located in the homeless shelters in both Huntington and Charleston and are actively involved in the Huntington Homeless Coalition and the Charleston Area Coalition. The outreach social workers provide homeless veterans access to VA and Mental Health services, eligibility services, and surplus clothing from the Department of Defense such as boots, fatigues, winter coats, sleeping bags, etc. The veterans also have access to Laurelwood, a transitional residential care facility located in Huntington, WV. The veterans can stay up to a maximum of 180 days when placed at Laurelwood and receive extended VA substance abuse treatment and non-VA substance abuse related services. The goal of the Laurelwood program is to facilitate veteran's reintegration back into the community.

Another program that will soon be available to homeless veterans is the Guthrie Project. Work is continuing through the Charleston Homeless Coalition to reconstruct and redevelop 18 houses at the old Guthrie Air Force Base located near Charleston, WV. A total of $3,000,000 in grants has been awarded with six of the reconstructed houses to be developed to provide for homeless veterans' specific needs. One of those six houses is being completely rebuilt to meet the needs of SCI and other wheelchair bound veterans. Guthrie graduates will have been trained, will maintain competitive employment while living at Guthrie with supportive services, and will ultimately be able to move into their own homes. Supportive services will continue as needed to ensure success.

Mr. Chairman, Huntington VAMC is proud to serve our veterans in a caring and compassionate manner. We are most appreciative of your interest in the needs of the nation's veterans and the support you have shown them as well as us. This con-

cludes my statement, and I will be happy to answer any questions you or other Committee members may have.

Chairman ROCKEFELLER. John Dandridge, we are happy to have you. Incidentally, we thank both of you for coming here, unless you both live in Huntington, which I don't think you do, so thanks for coming.

STATEMENT OF JOHN DANDRIDGE, JR., DIRECTOR, VA MIDSOUTH HEALTH CARE NETWORK, DEPARTMENT OF VETERANS' AFFAIRS, NASHVILLE, TN

Mr. DANDRIDGE. Thank you, Mr. Chairman, members of the committee, distinguished veterans, and guests. It is my pleasure to have this opportunity to be here today to talk about VISN 9's efforts to address issues of access and quality for veterans in rural settings.

I would also like to express our appreciation to you and your dedication and commitment to veterans' health service issues and to the VA in your capacity as Senator for the State of West Virginia, as well as both member and now chair of the committee. We have been very fortunate over the years to have been the beneficiary of your interest and look forward to its continuation.

Like yourself, I am personally committed, as well as professionally committed, to the service of veterans and their needs as a Network Director in the VA. The mission of our network is to provide comprehensive, appropriate health care to our veterans with the emphasis on improving quality, improving access, as well as the efficiency in which we provide care, and certainly with a mind to being as cost effective as we can.

Our network is comprised of six core hospitals in the States of West Virginia, Tennessee, and Kentucky. Our service area covers approximately 150 square miles. We service 262 counties. We have as part of our service configuration 26 outpatient centers, three of which are core satellites, comprehensive centers, and 23 CBOC's.

Our direction over the past couple of years has been to focus on ways in which we can improve access. Last year, we engaged an outside consultant. We utilized the benefit of that expertise to assist us in trying to determine ways in which we can improve access to our veterans with a focus on trying to reach at least 80 percent of our population such that they would have access to a primary care setting within 30 minutes.

We were very inclusive in that we called upon our three State commissioners and other stakeholders to participate both in the planning as well as in the siting of centers as we began to roll them out over the last year-and-a-half. We believe that that has been very, very helpful in enabling us to make the best possible decisions in terms of where to locate our centers, and we have developed at least seven centers a year over the past several years.

In terms of continuity and quality, we rely very heavily on CPRS as a tool which we use within the VA and within our network specifically. What CPRS enables us to do, both in our contract sites——

Chairman ROCKEFELLER. CPRS?

Mr. DANDRIDGE. Yes, that is the computerized patient record system.

Chairman ROCKEFELLER. OK. You have got to tell me that, then. [Laughter.]

Mr. DANDRIDGE. Because what it enables us to do is to look at and profile just how care is being conducted at each of our sites. Our contract sites will not be renewed unless they actually include CPRS as part of their capability, as well.

Mental health is an area that we are very interested in. We have recently selected a physician by the name of Dr. Godleski, who is at Louisville. She is our mental health product line manager. She and her team are currently working on a plan that will enable us to define how we can best improve mental health services within our network. We are looking at such things as having psychiatrists rotate between the various sites, wherever feasible, looking at community placement, and assigning additional social workers where that makes sense. We are looking at opportunities to improve mental health.

As you know and as you have indicated, all of us have had budget challenges. Network 9 was one of the first networks to go into headquarters for a supplemental in, I guess it was 1999. We received a loan and we were able to pay back that loan from the reserves that we were able to carry forward that year. Last year, our reserve was approximately $11.8 million. We paid the loan, as well as used remaining funds to address outreach initiatives for our network.

The next year coming is going to be very challenging for us. We——

Chairman ROCKEFELLER. How do you pay back a loan? I mean, you have got to pay back a loan——

Mr. DANDRIDGE. Well, it was a lot of hard work on the part of the facility directors, looking at ways to be as cost efficient as possible. And with the increased budget for the year 2000, it enabled us to use some of those funds to pay back the $5 million which we borrowed. We also converted some of our NRM dollars, which was money——

Chairman ROCKEFELLER. What is that?

Mr. DANDRIDGE. Non-reoccurring maintenance dollars, which are funds that we use to address infrastructure needs in our facilities. In fact, we will do that this year, as well, to the tune of about $1 million.

That will conclude my comments. Certainly, you have my testimony for the record——

Chairman ROCKEFELLER. Right.

Mr. DANDRIDGE [continuing]. And I am available to be responsive to any questions that you might have as a part of these proceedings.

Chairman ROCKEFELLER. Yes. Deferring maintenance is tough.

[The prepared statement of Mr. Dandridge follows:]

PREPARED STATEMENT OF JOHN DANDRIDGE, JR., DIRECTOR, VA MIDSOUTH HEALTH CARE NETWORK, DEPARTMENT OF VETERANS AFFAIRS, NASHVILLE, TN

Mr. Chairman, members of the committee, distinguished veterans, and guests:

Thank you for this opportunity to appear before you today to address VISN 9's efforts to provide access and quality of care for veterans in rural settings. I am committed to our veterans, personally and professionally. Our mission is to provide comprehensive, appropriate health care services to veterans consistent with mandated

benefits, and to manage the provision of services in the optimal setting in order to provide high quality, accessible, cost-efficient care. Our guiding principles are to enhance quality, improve access and customer service as well as reduce costs.

OVERVIEW

The MidSouth Healthcare Network provides healthcare services to over a million veterans in Tennessee, Kentucky, West Virginia, Mississippi, Arkansas, Virginia, Georgia, Indiana and Ohio. There are 262 counties—over 150,000 square miles—within the MidSouth Healthcare Network service area. The Network is comprised of six core medical centers, three nursing home care facilities, one domiciliary, three long-standing satellite outpatient clinics and 23 community-based clinics. We have strategically located these clinics to improve veterans' access to care.

Twenty percent of the veterans residing in the VISN 9 geographic area live in three urban areas around Louisville, Memphis and Nashville.

Healthcare responsibility for West Virginia veterans is shared among four networks. VISN 9 is responsible for provision of services to 10 of the 55 counties in West Virginia. The VISN 9's geographic service area accounts for approximately 59,000 of the states 200,000 veterans. Almost half of the West Virginia veterans in our service area reside in one county—Kanawha County.

ACCESS

Our Network realized early the need to address rural health issues among veterans residing in underserved areas as well as the need to develop strong working relationships with non-VA area healthcare providers. A core strategy of the Network is to provide 80% of eligible veterans access to primary care within 30 minutes of their homes. During FY 1999 we engaged an outside consultant to help us identify a strategic direction for VISN 9 as well as opportunities to improve access. The result of our planning was a conceptual methodology to aid in the identification and siting of future community based outpatients clinics (CBOCs). We included our affiliates and other stakeholder groups early in development of this methodology as well as our annual CBOC site selection process. We organized a workgroup comprised of the State Commissioners from three states, consumer representatives and VISN staff to provide input and recommendations for locating community clinics and for addressing access issues including access to long-term care and mental health services. This has provided us a sound and inclusive process for establishing future community based clinics. This collaborative is serving our veterans and the Network well.

As a Network, we have developed six to seven clinics per year over the past three years. Currently, we have CBOCs located in seven states. There are eight clinics in Tennessee, seven in Kentucky, three in West Virginia, two each in Mississippi and Virginia, and one each in Indiana and Arkansas.

We target locations based on access needs, geographic and topographic challenges and opportunities in order to decompress workloads at the VA main campuses, thus improving access to care and decreasing hospital wait times.

Throughout VISN 9 there has been an increase in outpatient visits and decrease in admissions to inpatient care. We have seen our acute bed days of care drop from around 2,600 per 1000 unique veterans served in FY 1996 to a current level of around 800 per 1000 and our Average daily census drop from 2,605 to 1,470. Concurrently, due in large part to the accessibility of care in the outpatient/ambulatory setting, we have experienced an increase of more than 700,000 outpatient encounters between FY 1996 and FY 2000. This movement from inpatient based care to outpatient based care is not endemic to VISN 9, but throughout the system. We have to manage and coordinate care among our VISN 9 facilities, other VA centers outside of our VISN and among resources available in the community.

CONTINUITY/COORDINATION OF CARE

A key part of quality is continuity and coordination of care. Within VISN 9 we decided to ensure continuity of care by mandating that the VHA's Computerized Patient Records System (CPRS) be utilized in all our CBOCs, staffed as well as contract. This decision was made a number of years ago. Full implementation was pending the development of an internal Wide Area Network as well as implementation of CPRS standards within VISN 9. I am glad to say that both of these elements have been accomplished. We use CPRS to review and monitor clinical documentation and conduct chart reviews at each site. By mandating CPRS, the patient record and services provided are always available.

The recently staffed and contract sites will all be functional users of CPRS. We have informed existing contract sites that contract renewal will require their imple-

mentation of CPRS. Each of our VA-staffed sites has implemented CPRS. The importance of this is not only to ensure that there is continuity of care received by our veteran patients but also to have an electronic mechanism to review services provided and monitor the actual services, their documentation and eventually the quality of care. Implementation of the computerized patient record is only one technological advancement we have pursued. We are also actively piloting the use of telemedicine/tele-psychiatry at the Huntington VAMC. Mr. David Pennington will address that in more detail.

MENTAL HEALTH

Recognizing the significant role psychiatric care plays in the health of our veterans, we established a Network-level Mental Health service line headed by a psychiatrist who is proving to be a strong advocate for mental health care. She has already spent a considerable amount of time reviewing mental health programs within our Network and has initiated a plan to address access to care for veterans needing psychiatric care. Mental health follow-up has shown overall improvement since the Network appointment of Dr. Linda Godleski. At our VA staffed clinic sites, mental health screening is routinely conducted. We then rely upon referrals from the clinics for treatment at our main facilities. We are considering options for further enhancement:

- Enlist a 'traveling psychiatrist' to visit the CBOCs rotating appointment days
- Utilize a social worker to more aggressively focus on mental health issues
- Contract for services with area resources
- Widely use tele-psychiatry

We are committed to the provision of appropriate Mental Health Services at each of our locations.

LONG TERM CARE

In an effort to conform to the terms of the Millennium Act, VISN 9 will re-establish additional long term care beds in order to achieve an Average Daily Census (ADC) level of 411 beds—an increase of 122 ADC over current levels. As a network, we must assess where the 122 beds will be located. VISN 9 is addressing the long-term care needs of our veterans and maintaining necessary facilities. Our current planning includes assessing what capacity we have within our existing Medical Centers particularly at Murfreesboro, Mountain Home, Lexington and Memphis. We also must remain cognizant of the culture and environment in which care is delivered and respond to the desires of our veterans and their family members.

BUDGET

I appreciate the strong support you have given VA in your past role as Ranking Member of the Senate Committee on Veterans' Affairs, as a West Virginia Senator, and now as Chairman of the Veterans' Affairs Committee. This has meant a great deal to us as leaders and managers in VA healthcare and to our veterans.

We carried over $11.8 million from FY 2000 to our FY 2001 budget. The prior year, (FY 1999), in order to avoid a projected $16 million dollar shortfall, we converted equipment dollars as well as requested a $5 million dollar loan from VA Headquarters. With the $11.8 million carryover, we were able to repay the prior year's loan, and establish 5 CBOCs within the Network. Additionally, we earmarked remaining funds to address waiting times for access to primary and specialty care.

This year we have to address significant increases in costs resulting from greater utilization of pharmaceuticals, increase demand for services, continued growth in prosthetics utilization, higher utility cost and Millennium Act program costs.

While we do expect to meet our budget this year we will not have any significant carry over of funds and currently have converted $1 million in minor construction dollars.

We are currently in the process of budget and workload projections for FY 2002 and while I am unable to comment on what our financial condition for next year will be, I will note that preliminary indications are that we will not be in a position to continue to expand community based clinic access. We will focus on expansion of community based mental health services; reinstitution of facility based long term care beds, decreasing waiting times and improving access to specialty services.

Overall, we attempt to retain some flexibility with our resources. It is generally prudent to maintain a reasonable allotment of funds to support new initiatives and be able to address unanticipated needs. This is how we are able to sustain new initiatives and unanticipated requirements until funding is received. As a Network we are always challenged to address the many competing needs and interests. We have

to make choices and set priorities within the scope of available resources, however, we do this with input from our stakeholders.

CONCLUSION

I hope the information I have shared with you is helpful. Thank you for your continued support of our Nation's veterans. I, along with members of my staff, am available to address any questions you may have at this time.

Chairman ROCKEFELLER. Charlie, before you go out, I want to thank you for being here. It is important symbolically, and typical of you in all the years I have known you. You have got the head man at the Marshall Medical School sitting right here. It is what we need to see as much as possible for the future of our veterans' health care because you are right here listening, and I really do appreciate it, so I want to thank you for that.

Dr. MCKOWN. Thank you. Thank you for being here.

Chairman ROCKEFELLER. Becky, please.

STATEMENT OF REBECCA FOX, CLINICAL SUPPORT MANAGER, MID-ATLANTIC HEALTH CARE NETWORK, DEPARTMENT OF VETERANS AFFAIRS, DURHAM, NC

Ms. FOX. Thank you for the opportunity to be here this morning to talk about VISN 6's efforts to provide the right care and the right setting at the right time for the veterans of West Virginia, particularly those served by Beckley. As we have already talked about this morning, a lack of a tertiary care VA medical center in West Virginia results in inherent challenges to coordination of care.

In fiscal year 2000, VISN 6 facilities, including Ashville, Durham, Richmond, and Salem, treated 1,793 West Virginia veterans. In fiscal year 2001 to date, Richmond and Salem alone have treated 2,103 West Virginia veterans. This includes 123 inpatient transfers from Beckley plus 13 other transfers from VA medical centers in West Virginia or from the private sector facilities in West Virginia.

Chairman ROCKEFELLER. Is that separate veterans, or are the visits sometimes meaning the same veterans?

Ms. FOX. They are separate veterans.

Chairman ROCKEFELLER. Separate veterans, OK.

Ms. FOX. Separate veterans. Beckley provides primary and secondary diagnostic and therapeutic services, outpatient mental health services, an array of long-term care services from skilled rehab to respite care. Beckley does rely heavily on VISN 6's tertiary care medical centers to meet the complex care needs of veterans. They often refer medical specialties, such as cardiology, rheumatology, endocrinology, and surgery specialties, including orthopedics and ENT, to VISN 6 facilities.

These services are provided on either an outpatient or an inpatient basis. Urgent acute inpatient care is either provided at Beckley, or in the community if the patient's condition warrants, or at a VISN 6 tertiary care facility, providing the clinician has deemed that it is safe to transport the patient. The facility routinely contracts for some services in the community, including radiation therapy, mammography, contract dialysis, neurology, and dermatology.

Salem is the primary referral site for mental health care. They accept Beckley's patients on a 24/7 basis because they understand the limited ability at Beckley to provide acute mental health care.

VISN 6 actions that we have taken to try and increase the coordination of transfers include the implementation of a VISN-wide transfer policy and identification of points of contact at all of our eight sites on a 24-hour, 7-day-a-week basis. The outcomes from this policy have been there has been improved communication regarding transfers across all sites, and also a reduced time to actually get a patient transferred. We also monitor monthly waiting times for specialty appointments and facility actions regarding how they are going to reduce waiting times.

Specifically at Beckley——

Chairman ROCKEFELLER. What does that mean, what you just said? You monitor and then——

Ms. FOX. We monitor the waiting times, how long it takes for patients to get appointments for specialty clinics. We look at that monthly, and for each month, if the specialty clinic waiting time is beyond 45 days, facilities turn in an action plan for how they are going to address the waiting times, whether it is more space, whether it is more providers, whether they are adding Saturday clinics, whether they are adding evening hours. All of those things are parts of what is included in that monitoring.

Additionally, we have added, recently constructed and activated an audiology suite at Beckley. We have added an optometrist to the Beckley VA staff. Funding has been provided for additional staffing in primary care and specialty care at Beckley. There has recently been approval for a project to add an additional floor at Beckley and to renovate existing space for more efficient outpatient clinic utilization. This will include specialty care clinics.

We basically have also added staff at the referral sites. We have added monitored beds at the Salem VA. We have used tele-medicine to improve access to care. Examples of that include mental health care between Salem and Beckley, SCI care, endocrinology, and pathology care between Beckley and Richmond.

Despite the above actions, the nursing shortage at Salem and at Richmond, as well as difficulty recruiting specialists at Beckley, Salem, and Richmond impact the timely transfer and delivery of specialty care.

We look at access to and coordination of care and monitor that through inpatient/outpatient satisfaction surveys, transfer logs, again, clinic waiting times. We also track the scheduling of consults. There is frequently chief-of-staff/chief-of-staff interaction and followup if there are consults that are pending beyond 30 days between facilities to try and get those patients seen.

In addition to that, we try to communicate programmatic changes with their VSO's and let them know of planned projects and how we are trying to address the access issue and share the waiting time information across the VISN with the facilities and with the VSO's at the MAC meetings. Veterans and their families, if they have questions or concerns about transfers, can speak with either their primary care provider, the patient advocate at the facility, or the patient transfer coordinator.

In summary, we are really committed to providing timely access for West Virginia veterans through VISN 6 facilities. It is our intent and goal that delivery of the care and any required coordination be transparent to the veteran and seamless.

Chairman ROCKEFELLER. Thank you, Becky.
[The prepared statement of Ms. Fox follows:]

PREPARED STATEMENT OF REBECCA FOX, CLINICAL SUPPORT MANAGER, MID-ATLANTIC HEALTH CARE NETWORK, DEPARTMENT OF VETERANS AFFAIRS, DURHAM, NC

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to speak before you today regarding VISN 6 efforts to ensure the right care at the right time in the right setting to veterans in West Virginia, particularly those served by Beckley. The lack of a tertiary referral VA Medical Center (VAMC) in West Virginia results in inherent challenges to coordination of care.

FISCAL YEAR 2000 AND 2001 TRANSFER DATA

In FY 2000, VISN 6 facilities provided care to 1,793 WV veterans at VAMCs Richmond, Salem, Durham, and Asheville. In FY 2001 to date, Beckley has facilitated 123 inpatient transfers to other VISN 6 facilities. VAMC Salem has provided care to a total of 1,050 WV veterans; this represents 6,143 clinic visits and 203 veterans treated as inpatients. In FY 2001 to date, Richmond has accepted 79 inpatient transfers from WV VAMCs. Patients are primarily referred to Richmond from VAMCs Huntington and Clarksburg for spinal cord injury care, traumatic brain injury care, and cardiac care. Of the WV veterans referred to Richmond, thirteen were from non-VISN 6 sites in WV.

BECKLEY VAMC

The Beckley VAMC offers primary and secondary diagnostic and therapeutic health services, outpatient mental health services, diagnostic services and long-term care from skilled rehabilitative services to comfort care and respite services. The medical center relies heavily on the other VISN tertiary care medical centers, particularly Salem and Richmond to support the complex care needs of the Beckley VAMC patients. Beckley routinely refers patients to other VISN 6 facilities for acute consultation such as Cardiology, Gastroenterology, other medical sub-specialties, Orthopedics, ENT, other surgical specialties, and Spinal Cord Injury (SCI) care. These consultations occur in either the inpatient or outpatient setting depending on the veteran's unique needs. Veterans are routinely referred by Beckley to local, private sector facilities for chronic dialysis, cancer radiation therapy, mammography, dermatology, neurology and all home health services. Veterans requiring Alzheimers special care are referred to community long-term care facilities. In urgent situations, Beckley also refers veterans with acute care needs to the community.

VAMC Salem serves as the primary referral site for inpatient Mental Health services; however, on occasion these veterans are referred either to the community in the event of pending legal actions or to another VAMC if Salem does not have beds. Mental Health patients have also been transferred to Martinsburg and Clarksburg if beds are not available at Salem. Salem accepts Mental Health patients on a "24/7" basis due to Beckley's limited ability to provide this acute care.

VISN 6 ACTIONS TO IMPROVE ACCESS TO CARE

VISN 6 has initiated numerous actions to address the issues encountered by Beckley in transferring patients for tertiary care to improve the timeliness of referrals and transfers and to ensure that the appropriate care is provided. VISN 6 actions include:

- Creation of an interdisciplinary VISN team to redesign and refine the transfer process to ensure consistent safe transfer of patients with an emphasis on improved communication among the facilities. The result of this process is a VISN-level transfer policy with a consistent approach to transfers and identification of points of contact for transfers on a 24 hour, seven-day basis. Indicators developed to monitor the effectiveness of the redesign and quarterly reviews of the monitor results show that there has been improvement in communication between facilities regarding transfers, a decrease in the average length of time for transfer, and an increase in patients meeting criteria for admission. The frequency of transfers that must either be referred to another VA or to the private sector is also monitored.
- Identification of a transfer coordinator at each site to coordinate both inpatient transfers and outpatient consultations. This individual coordinates record transfers and promotes communication between clinicians at both facilities.
- Monthly monitoring of waiting times and facility-initiated actions to reduce waiting times for specialty clinic appointments and primary care. There are mechanisms in place for urgent outpatient consultations when there are prolonged waiting

times for next available appointments. Reduction of waiting times for specialty care is also the focus of a new VISN initiative to spread access and efficiency changes identified by the Institute for Health Care Improvement.

• Construction and activation of an Audiology suite at Beckley VAMC in FY 2000. This service had previously been provided in the community at less convenience for veterans.

• Funding of an optometrist on-site at Beckley VAMC.

• Funding of additional staff to support Primary and Specialty care services. VAMC Beckley received the largest percentage increase in their FY 2001 budget of any VISN 6 facility.

• Support for telemedicine initiatives to improve access to care for West Virginia veterans. Examples include use of telemedicine in the provision of Mental Health care between Salem and Beckley; SCI care through Richmond; pre-transplant care through Richmond; Pathology services through Richmond; and endocrinology consultation.

• Increased resources for specialty care delivery at referral sites.

• Funding for additional 8 monitored beds at Salem VAMC.

• Approval of a project for an additional floor and renovation to add space for specialty care clinics and allow more efficient outpatient clinic operations at Beckley.

• Purchase of a bus and funding a driver to transport veterans from Beckley to Richmond. This is in addition to the fleet of 12 vans comprised of DAV and WV state supplied vehicles driven by volunteer drivers. All but two vans are outplaced in the various counties served by Beckley. The two on site are utilized for both local and long distance runs. This has been particularly helpful to veterans served by Beckley.

• Additional actions taken by Richmond VAMC to facilitate the referral process include: assignment of a lodger coordinator to facilitate lodging patients who are receiving outpatient care; an outpatient transfer coordinator who receives, forwards, and monitors referrals for specialty care from other VAMCs; assignment of a nurse administrator in the SCI Service to assist with coordination of SCI patient care; development of VISTA software to make special transportation needs of patients available to administrative and clinical staff; identification of a roster of contacts at other facilities involved in transfer of patients; and implementation of computer applications that enable physicians at each facility within the VISN to access patients' medical records at other VISN 6 VAMCs.

Difficulties in recruiting nurses and physician specialists at Beckley, as well as at Salem and Richmond, are having an impact on transfers and referrals for specialty care.

MONITORING

Access to care and coordination of care is monitored through:

• inpatient and outpatient satisfaction surveys and call-backs;

• inpatient transfer logs;

• monthly clinic waiting times both at the VISN and facility level with action plans developed for clinics with excessive delays;

• tracking scheduling of consults and appointments at the referral facility;

• VISN inter-facility transfer monitors; and

• SCI patient satisfaction surveys.

When problems have been identified, actions have been taken. Examples include:

• if the specialty is offered at Beckley, making attempts to address the access issue locally;

• follow-up on pending consults between the Chiefs of Staff of the involved facilities;

• plans in progress for an SCI inpatient room and initiation of group education activities at Beckley; and

• redesign of the transfer process at Beckley and the VISN level transfer process redesign.

COMMUNICATION

The VISN communicates with veterans and VSOs at the VISN Management Assistance Council (MAC), and facilities have regular meetings with local VSOs. Problems identified by veterans as well as facility changes in services and planned projects are routinely discussed. For example, concerns regarding transportation of West Virginia veterans to referral sites discussed at the MAC prompted the purchase of a bus by the VISN to facilitate transfers. A

medical center "update" is also provided at service officers' meetings. Beckley strives to keep SCI veterans informed of SCI services through the involvement of

IPVA at meetings with the SCI team and at bimonthly service line advisory committee meetings. The PVA monthly newsletter also contains a section on SCI news at Beckley. This is yet another avenue for communicating with veterans and addressing their concerns.

Veterans and their families have ready access to their primary care providers as well as facility-level patient advocates and the patient transfer coordinator to communicate their questions and concerns.

VISN 6 is committed to providing timely access to care for West Virginia veterans through facilities and local providers and through our tertiary and acute care facilities in Virginia and North Carolina. It is our intent and goal that delivery of care and any required coordination is seamless and transparent to the veterans we serve.

This concludes my remarks. I will be glad to respond to any questions that you have.

Chairman ROCKEFELLER. I find that when I am listening to a panelist and we can talk about things that aren't going right as well as things that are going right, it somehow becomes a better piece of testimony, and you did mention the nursing shortage.

Ms. FOX. Absolutely.

Chairman ROCKEFELLER. But pretty much everything else you said, we are doing this right. I just say that because life doesn't usually work like that. I know there are things that you worry about, and I am going to come to you in a little bit on that.

This is to all of you. I think the nursing shortage at Huntington is a little bit less severe than it is in some of our other West Virginia medical centers. Nevertheless, at our hearing in Washington, we had Sandy McMeans—a nurse from the VA Medical Center in Martinsburg—testify. She gave a terrific view on the whole question about too few nurses taking care of too many sick patients and what it does to you in general, how it kind of exhausts you, breaks you down, compounded by the whole issue of mandatory overtime.

John, this may affect you less, but maybe I am wrong. Can you each give your view on how critical you think that situation is and is likely to become—in other words, the trend as well as the fact.

Mr. DANDRIDGE. Yes, Senator. I guess I will start. For me, I have been in health care long enough that I have seen this come full cycle, repeating itself from the late 1970's and early 1980's. Certainly, I would say that there, in my opinion, are a number of factors that, over time, may have contributed to this, and I think, in part, some of it has even been professionally driven in terms of some of the shifts in the general expectations that we move more toward a bachelor's degree and MSN and rely less on associate degree programs.

I think, also, it is complicated by the fact that we are seeing a change in the makeup of our nurse profile and perhaps even the level of interest in nursing as a career, certainly acknowledging the fact that, as a society, we have been more embracing of the gender that has traditionally gone into nursing and they have found opportunities in more professional areas. I mean, they are astronauts, they are doctors, and many other professions that were traditionally not available to a large portion of our female population years ago. I think that as we look toward the next 2 years, we are going to see the problem become more exacerbated.

From my vantage point, I think there are some things that perhaps we can do maybe better. Certainly one is looking at the functions that we currently have our nurses performing in our hospitals. We still have some facilities that are functioning with vir-

tually all RN staffs and there are other duties that could more appropriately be carried out by nursing aides, nursing assistants, pharmacy techs, pharmacy attendants, and others.

Chairman ROCKEFELLER. So, how are we addressing that?

Mr. DANDRIDGE. Well, I think that we have to really look at the distribution of work and then make a clear——

Chairman ROCKEFELLER. Are you free to do what you want?

Mr. DANDRIDGE. Well, I would not say totally free——

Chairman ROCKEFELLER. I understand that, but in other words, if you come up with a particularly good way of doing a mix that provides a net better health care possibility or outcome, you could go ahead and do it?

Mr. DANDRIDGE. I believe that I am, sir. I certainly believe that I have a responsibility to work with nursing union leadership in that we are communicating, that we are discussing and working together on some of these things that could result in changes or a necessity to renegotiate contracts. I certainly believe that I have the flexibility, as long as I am coordinating and communicating with headquarters. That is not to say that everything that I might consider or propose would get done, but I think there is considerable flexibility.

Chairman ROCKEFELLER. Do you think that physicians are opening up more? Actually, I would be interested to hear also on women physicians, of whom there are a great many more these days, are they flexible in their openness to nurses taking on more responsibility or is that so-called old-time attitude still there?

Mr. DANDRIDGE. I think it has changed and changed for the better. I think there has been a lot of emphasis on the team as a collaborative approach to supporting and meeting the needs of our veterans. I think that is particularly strong in the VA, and as I stated, I think that is a positive. So, I mean, certainly there are always going to be individual exceptions, but I think, overall, there is a strong team spirit that works together through the difficult times as well as the good times.

Chairman ROCKEFELLER. Are there other comments from the panel on that shortage?

Ms. FOX. The nursing shortage is particularly real for VISN 6 at Richmond and Durham, which are two tertiary care facilities, and if you look geographically with Richmond and MCV and probably six hospitals within three miles of the facility, and the same thing with Durham, with Duke and UNC hospitals very close by, it is a really competitive environment.

I think that the facilities have done very well with recruiting and retaining the nurses they have. They are really focusing on retention versus recruitment and they have been given a lot of leeway. Everyone in the network acknowledges the looming crisis and the fact that enrollments in the schools of nursing have gone down and we are doing what we can, such as the VA cadet programs, to try and spread that across the network so that we can stimulate an interest in careers in nursing.

I do think that practice is now much more collaborative and I think there is definitely a partnership between physicians and nurses and a recognition that each has a unique contribution to the team.

Chairman ROCKEFELLER. OK. David, do you agree with that?

Mr. PENNINGTON. Senator, I would echo both of the comments. We have been fortunate here in the tri-State area because we have a number of nursing programs. We have more graduates than in many other locations.

Chairman ROCKEFELLER. Right.

Mr. PENNINGTON. We have hosted——

Chairman ROCKEFELLER. Marshall helps.

Mr. PENNINGTON. Marshall certainly helps, and we have hosted recruitment fairs to try to help our sister VA's. John has encouraged a great deal of flexibility within the sites that he manages in respect to multi-function health care techs, which we are using in some of our clinics, and to give as much flexibility as we can in respect to those duties.

I think that part of what we are seeing as a challenge these days is that the aging curve in regards to the World War II veteran requires a much more intense level of need, and I think that is where a lot of the challenges come in respect to nursing for the VA.

Chairman ROCKEFELLER. Could I ask and just get a quick answer, do VA hospitals have transfer directors or coordinators, or how is that done?

Mr. PENNINGTON. I can say specifically, in regards to Huntington, I have a three-RN staff that report directly to the Chief of Staff that are involved with all transfers, both in and out of the facility, all transplant cases, and any special needs that a veteran may require at another VA or in the community, plus home health care.

Chairman ROCKEFELLER. So they will monitor when buses leave, when they get there, vans, et cetera?

Mr. PENNINGTON. Absolutely. I expect that office to report to the Chief of Staff and to myself on a daily basis any particular needs or crises and I expect them to get the veterans where they need to be in a timely manner.

Chairman ROCKEFELLER. Do they report back problems?

Mr. PENNINGTON. Absolutely. They are rather vocal RN's, and I encourage them to be that way.

Chairman ROCKEFELLER. Yes. Yes.

Ms. FOX. That is the case in VISN 6, as well. We have designated transfer coordinators. They are a mixture of RNs and administrative staff. We have people who can accept transfers 24/7 and they do a good job of it. Any problems that come up in terms of transfers from contract hospitals or from other facilities are discussed in the morning meetings, so we do have that function in place.

Chairman ROCKEFELLER. OK. You mentioned the computerized patient records. You gave it a different——

Mr. DANDRIDGE. CPRS is the acronym, yes.

Chairman ROCKEFELLER. CPRS.

Mr. DANDRIDGE. We have lots of those.

Chairman ROCKEFELLER. Now, that is obviously crucial, and one of the shocking things in this country is how many of our government agencies—I mean, the Senate didn't even have an Internet service until 4 or 5 years ago, so getting everything computerized is easy to say, but it is hard to do. Of course, it is not the only key

to care coordination, particularly for veterans who require very special kinds of care, including some that might only be available in the private sector.

How do you work that? This is to anybody who wants to answer it, but obviously——

Mr. DANDRIDGE. Well, I think perhaps there is a two-part answer to the question, and one is how are we doing it and the other is what might still be some of the possibilities or opportunities.

As already responded to, we do have care coordinators in our network. It was one of the earlier challenges that I undertook as a new network director, taking the lead from Huntington here in West Virginia that had been very aggressive and proactive in putting such a plan in place and trying to make certain that we did not have a Tower of Babel in respect to how those functions were organized, or not organized, as the case may be, so we can minimize breakdowns in communication.

I think we have such a system in place. I think it works generally well. Certainly from the testimony that has been given by the veterans that were in the earlier panel, it is obvious that there are things that we need to continue to be doing to improve service.

It troubles me to hear some of the logistical kinds of circumstances in which the veterans describe here today, and I think there are some things that we need to do more aggressively to look at better managing the logistics of getting the veterans to and from and situations where——

Chairman ROCKEFELLER. It sounds like timing is one of the answers.

Mr. DANDRIDGE. Well, I mean, for example, if one says that the bus leaves at—basically two departures, a specific time going and a specific time coming back, the answer would be, is that something that could be changed, and why not change it such that it gives them more extended time?

The comment regarding overnight stay, I am a product of the Medical College of Virginia. The Medical College of Virginia is a major tertiary hospital. Patients come from all over the world for heart transplants, et cetera. They had a facility akin to a hospital. It was called Nelson Clinic.

They would not admit the patient to a hospital bed for a workup, which they might have to undergo maybe once a year or once every other year. They had a facility on or near the campus. Patients could come in for his or her testing and go back for the night have their meals and then go back to the hospital the next day for the continuation of tests. And if they required 2 days or 3 days of testing, they were accommodated accordingly.

This is not unheard of, or uncommon in health care, people trying to make a buck do it all the time. If you have someone that needs to come in, you go get them or you see that they get there and you treat them like kings and queens because you want them to come back. I don't know what is different or why it has to be different.

Chairman ROCKEFELLER. John, I want to get to that PTSD question. It is better understood, but there is still so much ahead of us, isn't there, on PTSD? I am interested in how you do that in a community outreach center, and again, the question of a group ap-

proach as opposed to a more individual approach or do you need both?

Mr. LOONEY. Well, you do need both. You spoke of safety. It is where the person feels most safe, in individual or in group. Certainly, it is hard for an individual to go from individual treatment into group. That is just expected. It is normal. But once they get into group, they find that it is easier for them to relate their experiences and get that acceptance from the other folks in the group and also the idea that one incident will encourage another incident to come up from another person's experience.

The whole idea of treating trauma is talking about the trauma. It is a cleansing process, as you talk about it. I am sure the folks you will be seeing this afternoon will want to talk about their trauma, and that is the most healthy thing to do, so talk about it, talk about their losses. If you don't talk about it, then it becomes very powerful in a negative way. So talking about it in a safe place is what we want to encourage.

Chairman ROCKEFELLER. As you don't talk about it, the more that you don't talk about it, the deeper it sinks in and the harder it is to talk about, is that right?

Mr. LOONEY. Correct. It is sort of like it develops a scar tissue and the scar tissue gets deeper and deeper and it causes more life problems as this scar tissue keeps building up.

Chairman ROCKEFELLER. There are a variety of alternative approaches to PTSD, not all of which involve just group counseling. Is word about them spreading out there in the community? In other words, everybody thought that PTSD was Vietnam until they discovered that it went back even to World War I. And then even further, we discovered that it spreads to many people throughout life, non-veterans just living life. I mean, PTSD is everywhere.

This country has managed to avoid dealing with mental health problems for so long, simply saying, well, it is a behavioral problem or something of that sort. It just boggled my mind. And the only program in the country that deals with it is Medicaid, to some extent, and VA. It is not an easy thing for Americans to deal with, is it?

Mr. LOONEY. No, it hasn't been. One of the things that has happened is that, with the Vietnam veterans, when they came back, they tend to cling among themselves and they started addressing the issue themselves and then advocated, and then some of the spin-offs that you see now are groups for domestic violence trauma, women and men sexually assaulted. Those are all spin-offs, because they are traumatized and the way you treat it is the general way you treat post-traumatic stress.

You also have another spin-off that I believe is real important is the working with critical incident debriefings with the first responders, your EMT's, police officers. When they come up on a particularly bad scene, in order to keep them in the service, you want to debrief them quickly. And if you don't debrief them quickly, then it becomes an ongoing problem to where you will eventually lose them from the service. What you want to do is to encourage the experienced people to stay in the service.

You mentioned, or you were talking about access to care. I have some access to care facts that relate to the CBOC, if you would

wish. We have a CBOC—that is a community-based outpatient clinic——

Chairman ROCKEFELLER. I know you change one letter and then you become a telephone company. [Laughter.]

Mr. LOONEY. We have worked real hard with these folks. They are very nice folks. They are very dedicated to the veterans. But some of the issues that the veterans come to me with is that new patients have to wait three to 4 weeks for an appointment.

Chairman ROCKEFELLER. So if you haven't established a problem, in other words——

Mr. LOONEY. If I haven't established a problem and I need to be treated by VA, then I have got to wait 3 to 4 weeks or go up to the VA hospital and go in as a walk-in. The CBOC's aren't set up to do walk-ins. We are working with a contract CBOC and not a VA-staffed CBOC.

Urgent care issues, even if I am in the system and I have the flu or some illness of that sort and I call the CBOC, I have to make sure I talk to the nurse. I just cannot talk to the receptionist. I have to talk to the nurse to get scheduled for an appointment. There are appointments available at the end of the day. They would squeeze me in.

If you are in the CBOC system and you miss an appointment to get your prescriptions renewed, then there is no followup for that. I had one veteran that missed his appointments. His prescription stopped. We tried to get him back on, turned back on. He called and talked to us. We called the hospital pharmacy, worked very well to get them out to him. But it failed him in that he went into the hospital with a stroke the same day that his blood pressure medication came to his house. So I would really like to see some way of addressing that issue to do some followup with the folks.

In this particular CBOC, they are scheduling followup appointments currently, this week, into February. So that raises a question——

Chairman ROCKEFELLER. Into February next?

Mr. LOONEY. Yes.

Chairman ROCKEFELLER. Really?

Mr. LOONEY. And that, to me, raises the question, particularly with contracts, is to set up some sort of a patient-to-practitioner ratio that is standardized, where we in VA can say, OK, we are sure that there are enough people on this station to address these issues and they don't have to wait until February, or we can make sure that we can followup with the fellows that missed their appointment.

Chairman ROCKEFELLER. Well, I appreciate that.

Are there any comments that any of you would like to make about any other subject or any subject—no, any subject dealing with veterans?

Mr. DANDRIDGE. Senator, one of the things that is included in my testimony, and certainly, I think, is consistent with an area that you are interested in, is the availability of long-term care services for our veterans. VISN 9, I am sad to say, is one of the networks that did not maintain capacity in respect to the 1998 requirements to maintain ADC beds and staff. We are currently assessing our current situation with the intent of having a plan into head-

quarters the end of July that will address how we intend to reestablish approximately 122 ADC for our veterans in VISN 9 and we will be looking across the network in respect to where we have patient units that may not currently be in use, looking at veteran population and demographics and other things to make a determination as to how best to accomplish this.

Chairman ROCKEFELLER. Yes. It obviously is not a complete program, but it is a beginning. It has just got to happen. It has got to happen. You can afford long-term care in this country if you are very rich and you can afford it if you are practically dead broke. But if you are anywhere in between, you can't touch it unless you just spend yourself out.

I really appreciate this. It is going to be tough for all of us in these coming years, I think, because of this budget situation. Budgets are considered by people sort of to be inanimate objects, but they are highly animate and they have everything to do with what kind of care people get or don't or whether you can keep people or not. So I really worry so much about the budget and the VA, so much about it. If you get $23 billion 1 year and $24 billion the second year, you can say, gee, I got a $1 billion increase. No, you didn't. You got a $700 million cut just to keep up with the cost of things.

I mean, I have already expressed my views on the human effect of the tax cut on veterans and others. We are going to see it across our Nation. We are going to see it in defense. We are going to see it in welfare reform. We are going to see it in education, people who stay in teaching and nursing, people who don't. But that is not the discussion of the day.

I want to really thank all of you for taking the time to come. You are professionals and you do good work.

You have your hand up in the back?

Mr. MITCHELL. Can I come forward a little bit?

Chairman ROCKEFELLER. Sure.

Mr. MITCHELL. I want to say something.

Chairman ROCKEFELLER. OK. I also want to thank Bill Brew, who is our staff director, and I want to thank you, too, Jennifer, very much, and Charlotte Moreland, wherever she is, and Julie Fischer.

Yes?

Mr. MITCHELL. I am James A. Mitchell. I am President of the Houdaville Retirees Association and I speak for World War II veterans because almost all of the men—I, myself, wanted to do that, but I am the President of the organization, which are almost all veterans of World War II. I gave Charlotte a copy of a letter to you that you can read about the payments that the men have to make at the VA hospital to the veterans of World War II. There is a lot of them can't afford to even pay that, so if you would check that over. I just wanted to say hello and tell you that I gave Charlotte a letter out there for you.

Chairman ROCKEFELLER. I appreciate that.

Mr. MITCHELL. Thank you for being here.

Chairman ROCKEFELLER. Thank you, sir.

You know, one thing in closing, and I have got to go because I want to go look at more of this flood situation because I think that

everybody concentrates on the physical devastation and sometimes what I worry about is the human devastation that lasts for years and years and years.

And that is another thing. I can remember the 1977 flood, which pretty much wiped out Matewan and parts of Williamson. We went ahead and built a huge wall, flood wall. Well, there may be no money to do those kinds of things. We have got 15 natural disaster crises going on in the country at this moment, of which we are one. Actually, I think there are 16 and we are one of them. What happens to all of this? I mean, this is where this question of money becomes important.

But I just wanted to say, John, I watched the night before last "Born on the Fourth of July" again. It is sort of like "October Sky." You just keep watching it. Wherever you see it, wherever you come into it, you just watch it. I happened to catch this one from the very beginning. It was the first time I have caught it from the very beginning other than when I saw it in the theater. But it is an extraordinary, powerful thing of the effect of war and the physical, psychological, emotional destruction of people and the incredible courage which they, in most cases, summon up to handle that, and in some cases, just can't.

But I was kind of pleased that I ran into that before I came down for this hearing, because it reminds you of the unbelievable human stakes that are in play here and how deep hurt can be and how long it can last and how cruel people can be, too, sometimes.

So with that, I thank everybody very much. I am going to go put on something a little bit more suitable to dealing with flood victims, and I really do thank you and I thank you particularly for coming.

[Applause.]

[Whereupon, at 12:06 p.m., the committee was adjourned.]

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